THE DEPARTMENT OF VETERANS AFFAIRS HEALTH CARE BUDGET MODELING AND METHODOLOGIES

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

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CONTENTS

June 23, 2005

THE DEPARTMENT OF VETERANS AFFAIRS HEALTH CARE BUDGET MODELING AND METHODOLOGIES

THURSDAY, JUNE 23, 2005

U.S. House of Representatives,
Committee on Veterans' Affairs,
Washington, D.C.

The Committee met, pursuant to call, at 10:30 a.m., in Room 334, Cannon House Office Building, Hon. Steve Buyer [Chairman of the Committee] presiding.

Present: Representatives Buyer, Bilirakis, Moran, Brown of South Carolina, Miller, Evans, Filner, Brown of Florida, Michaud, Herseth, Berkley, and Udall.

The Chairman. The full Committee on Veterans' Affairs will come to order. Today, June 23, 2005, we will conduct a hearing examining the budget modeling and methodologies used by the Department of Veterans' Affairs to develop veterans' health cost and utilization projections for future years. This hearing will come to order.

We are here today to examine the budget modeling and methodologies used by the Department of Veterans' Affairs to forecast the cost of veterans' health care and to project usage of the system for future years. The discretionary budget for health care accounts for about half of the VA's funding. More than 7 million veterans are enrolled in the VA system, and 5 million of them currently use the system. In 1996, before eligibility reform, there were about half that number in the system.

Since 1996, there has been a 1,200 percent increase in the lower priority enrollees, veterans who have no compensable service connected disabilities, who are not catastrophically disabled, or who have higher incomes. That is a twelve-fold increase in utilization. And we are treating the nonservice connected injuries and illnesses of our service disabled veterans.

In 1996, we did not see this coming. Yet, as anyone in the health care industry would tell us, forecasting is critically important to providing high quality care to those who are eligible to receive it. A budget is only as good as the data that informs it and the assumptions that are used to create it. And we must not only have good data, but

we must also have the right data, and we also must have the right assumptions in our forecasting. It is the heart of the budgetary process.

The purpose of today's hearing is to learn how we can more accurately forecast the health care demand. That job is complicated by operational challenges that we must acknowledge.

I suggest forecasting challenges of the model include not only the economic assumptions that are used, the effects of eligibility reform, the rise in pharmaceutical costs, and uncertainties of demand in connection with veterans returning from the global war on terror, the wars in Afghanistan and Iraq in particular, medical inflation, dental costs, accurate and adequate collections, expenditures, et cetera.

We must have a thoughtful and responsive process to ensure that health care will be there for our veterans. We must ask difficult questions today. We must question the assumptions, the data, the input, and assume that we can do better.

Our dialogue should help shed light on this very complex process that is critical to the long-term vitality of the health system for America's veterans. We owe our veterans the best of care.

Today, VA will provides quality health care that in many respects is the envy of the medical community, and we must preserve that quality. And I am proud of the jobs that are done by the men and women, the employees who care for our veterans in the VA. In fact the VA's new Under Secretary for Health, Dr. John Perlin, in his previous position was the first Deputy Under Secretary to regularly see patients at the Washington VA Medical Center. His new job has changed that a bit, but I understand that he has volunteered for the midnight shift, and I respect you for that. He exemplifies the very best and what is good about our system.

It is the responsibility of Congress and this Committee to ensure that Dr. Perlin has the resources necessary to do his job. Sound health care forecasting is essential to doing precisely that, and I look forward to this hearing and the engagement of my colleagues.

The only experience I share with my colleagues that I had with this prior to the TRICARE for Life, when we were under the CHAMPUS and we had the military retirees going through base closures. We were trying to figure out health care budgets, and we had this huge ebb and flow of a ghost population in and out of the health system, so our modeling had tremendous errors. We had a very extensive hearing on how to improve that. Once we went to TRICARE for Life we also brought predictability into the system. I don't know if you can call it a science. I suppose you can, you know, the science of health modeling, and then we can begin to be more accurate.

What is often being done in this town is everybody throws and uses numbers out there with regard to our budgets. Let's try to figure this out, and I have not seen that done in the 13 years I have been on this

Committee. And so we are going to do this today. This will be hard. It will be a heavy lift. And I think by reading the statements last night, all of you have put a tremendous effort in this, and I appreciate your efforts.

I now yield to Mr. Evans for opening statement.

MR. EVANS. Thank you, Mr. Chairman.

Budgets are not just numbers. They order our national priorities and establish policy. Sometimes it is easy to forget the human component when we talk about these numbers. Sometimes it is hard to remember that often the numbers we use are poor substitutes for the reality we are trying to measure. I look forward to hearing from all of our witnesses that appear before us today.

It is vitally important to accurately identify the real resource requirements of the VA health care system. It is vital that we then provide these resources free from arbitrary fiscal considerations. Sadly, it does not matter how accurate budget forecasts turn out to be, if those forecasts are not fully funded.

I agree with the voices of veterans who across the country have called our attention to the disparity between what the VA needs and what it too often gets. There was a concern with the presidential task force which drew attention to, quote, current mismanagement, including the demand for VA services and funding. My Assured Funding bill would do just that by requiring the Federal Government to provide adequate funding based on the number of veterans enrolled. I am looking forward to the hearing on H.R. 515. I look forward to the day when we are developing and providing veterans with benefits based on their need and their support.

Thank you, Mr. Chairman.

THE CHAIRMAN. Thank you, Mr. Evans. Any other colleagues have an opening statement?

Mr. Filner.

MR. FILNER. Just a question, if I may, for the Chairman. Clearly, the balance of powers in the Constitution gives us oversight authority over the executive branch, and this hearing is very important for the VA to come to us and let us know how they are doing. I would associate myself with the remarks Mr. Evans made about the budget process.

I frankly don't understand the second panel. That is, we do not have oversight over independent groups. The motivation for this panel is suspicious to me. The American Legion can say anything they want about the budget, and we can ask them when they testify how they came up with those figures. But for us to put VSOs in the equivalent position of the VA and demand that they be here and explain how they did something seems to me a hidden agenda, or not so hidden, a pretty open agenda. On the record, I want to object to the structure of this hearing.

Mr. Miller. Mr. Chairman, if I could ask Mr. Filner a question.

The Chairman. You are recognized for an opening statement.

Mr. Miller. My opening statement is without fail, year after year, that the annual budget for VA Health Administration is subject to great debate and we all know that more and more veterans are relying on VA for their health care needs. And it is important that we do understand the Department's methodology for forecasting health care costs and utilization projections. I do look forward to hearing from all of today's witnesses, and I do have a question for Mr. Filner.

I must be blind, but I don't understand. What do you think the agenda is with the second group of folks? I am sorry.

Mr. Filner. If the gentleman would yield, the Chairman has taken issue with the legitimacy of the Independent Budget in open hearings where some of us have used it as a Bible, and he wants to undermine the credibility of the Independent Budget in my view.

Mr. Miller. You may be a little mistaken when the hearing is over, but we all question the validity of the Independent Budget. So I put myself and associate myself with the Chairman in this particular case.

The Chairman. Does the gentleman yield back? Ms. Brown.

Ms. Brown of Florida.Thank you, Mr. Chairman. I want to thank all the witnesses here today to enlighten us as to how they determine future costs. I appreciate your explanations. But all of this discussion does not get to the root of the question. Every year the VA does its budget modeling, OMB has its views as to what the numbers should be and the Independent Budget comes out with its own numbers.

It seems almost as if everyone agrees that the VA needs more funding to complete its mission, the mission being to provide the best health care to our nation's veterans.

Everyone is discussing numbers. How can we cut costs, save a little bit here, cut some fat there? We are talking about people, and many of them come to my office. Are we budgeting for better health care for our veterans or are we budgeting for saving money?

The Independent Budget comes out with its estimates every year. A coalition of veterans groups get together and figure out what veterans need. The President comes out with his budget every year. This budget effects every aspect of our lives, and he decides to pay for the war in Iraq on the backs of our veterans.

The Independent Budgets say that we need an additional $3 billion, and I don't disagree with them. How can these two numbers be so different?

Everyone begins with the same starting point. There is a known number of veterans and a procedure costs X amounts of dollars. What happens to the VA's numbers after they are modeled when OMB gets ahold of them and cuts it by almost 90 percent? I mean the budget that VA starts out with and then when it goes to OMB, it is totally

different. What is the rationale for cutting veterans benefits?

Whether the veterans have a service connected rating of 100 percent or is Priority 8 and not homeless, each served his or her country honorably and deserves care from the VA.

I am hoping that this Committee can get back to its purpose of serving the veterans. We are independent from the administration, and we should act that way.

I yield back the balance of my time.

THE CHAIRMAN. Mr. Brown.

MR. BROWN OF SOUTH CAROLINA. Thank you, Mr. Chairman. I would like to thank you and the Ranking Member for holding today's hearings and highlighting an issue that I think is critical for all veterans, health care costs modeling and appropriate funding for health care of the VA.

First, Mr. Chairman, let me begin by welcoming and congratulating Dr. Perlin on his recent nomination and confirmation for his position of Under Secretary of Health at the VA. I believe that his assumption of that post marks an important milestone as this Committee continues to work with the VA to improve the quality of care provided to our Nation's veterans. So again welcome and congratulate you, Dr. Perlin.

In addition to Dr. Perlin, I believe we have two panels of folks here today that can help us better understand the efforts that VA goes through in determining how much funding is annually required to maintain the excellent care VA is providing nationwide.

It is my hope that my colleagues will come away today with a better sense of two important issues: Number one, the inherent challenge that faces those who try to accurately forecast the demands for care inside the VA; and number two, the level of strain it puts on the Department and our veterans when those projections fail to meet the mark. To that end I am interested in hearing today how the VA's modeling process compares to that of the Department of Defense, the Independent Budget, the American Legion demand model, and finally to help us look towards the private sector to gauge health care costs and demand for medical services.

More importantly, I want to explore how the VA can become more efficient in accurately engaging the demands for health services and how we as Members of the Congress can be assured that our veterans will continue to receive the level of care they have come to rely on.

Mr. Chairman, again I thank you and Ranking Member Evans for holding this hearing today. I look forward to the testimony of our panels in the hopes that we can explore the modeling process today. We continue to remember that the numbers are important, but our main concern should always be that our veterans are treated with respect and afforded the level of care that VA has become so efficient in providing.

Thank you, Mr. Chairman, and I yield back the balance of my time.

THE CHAIRMAN. Thank you, Mr. Brown.

Ms. Berkley.

MS. BERKLEY. Thank you, Mr. Chairman. I also think this is a very important hearing today, and I am very delighted that we are discussing the VA budget process and the modeling used to determine the future needs of our vets.

As you have heard me say on many occasions, southern Nevada has one of the fastest growing veteran populations in the country. Over 50,000 of my veterans depend on the VA for their health care needs. Every year it is very difficult going back home after our hearings and explaining to my veterans that their service organizations' projections and the amount of money that we know it would require to take care of our veterans adequately is not what we are voting on. They don't understand the disparity and they don't understand the difference.

Not only in my opinion should the VA use the most accurate tools to determine what veterans' needs will be in the future but we, Congress, must provide the resources that are necessary to provide health care services to our veterans, and I can never get out of my mind when we had hearings with then VA Secretary Principi and somebody asked the Secretary after he made his presentation on how much money he was requesting of Congress to satisfy the health care needs of the veterans. The question was asked, is this the amount that you presented to the President? His response was no. And apparently his presentation to the President had requested at least, if I am not mistaken, $1.2 billion more than he actually presented to Congress.

MR. FILNER. Would you yield on that point?

MS. BERKLEY. Yes, I will yield.

MR. FILNER. You bring up the key question that is going to be neglected on the first panel. I would ask the Chairman if he invited OMB to be here because it doesn't matter what the VA models. If OMB says no, OMB has the word on what the budget is going to be, and these models do not matter. OMB makes that decision, and we ought to be checking that; this is what we ought to be doing.

I yield back.

MS. BERKLEY. Thank you, Mr. Filner. And if I could reclaim my time, although I agree very much with what you are saying, I am also very concerned with our returning soldiers. The VA has treated more than 85,000 of the 360,000 veterans from Operation Iraqi Freedom and Enduring Freedom deployment as of May 2005.

Mr. Chairman, I have another protocol hearing for IR that I have to be at by 11 o'clock, but I have a question that I would like to submit, and I am very sorry I am not going to be here to listen to this.

THE CHAIRMAN. Mrs. Berkley, do you have it?

MS. BERKLEY. Yes.

THE CHAIRMAN. Why don't you ask it? They will write it down.

MS. BERKLEY. Great. If you can incorporate this into your comments, I would like to know how the VA is ensuring that returning soldiers are being put in these models and ensuring that they accurately project and provide the needed resources for these new veterans in the VA health care system. Southern Nevada is going to be overwhelmed by people coming home from Iraq, and not necessarily our current residents, but that is the place that the returning veterans are going to be moving, and we are going to need to ensure that we have the adequate resources for the needs of these veterans. And I suspect that they are going to be extraordinary needs, not only physical, but mental as well.

And I thank you, Mr. Chairman, for your courtesy.

THE CHAIRMAN. Thank you. Any other opening statements? Mr. Michaud.

MR. MICHAUD. Thank you very much, Mr. Chairman. I would like to thank you and Ranking Member Evans for having this hearing. I am looking forward to hearing the panel. I believe that budgets are a reflection of our priorities, Mr. Chairman. In the interest of time, I would ask that my opening statement be submitted for the record.

THE CHAIRMAN. Without objection.

Any other members have opening statement to be submitted for the record?

Hearing none, what I would like to do for my colleagues -- I don't normally do this, but I am going to introduce each one of these individuals that are in front of us on the first panel and I will also introduce right now the second panel and explain an opportunity that we have to be very constructive in the process here. And the reason I need to do this is the second panel is the Independent Budget and the American Legion that operates outside the Independent Budget. As we all know, under the rules the minority has rights and we in cooperation decide who the witnesses are going to be and the second panel is the request of the Democrats.

Dr. Jonathan Perlin serves as the Chief Executive Officer of the Veterans Health Administration, the country's largest integrated health system. Dr. Perlin recently was sworn in as the current Under Secretary for Health in the Department of Veterans' Affairs, having served as acting in that role since April of 2004. He has a background in health care quality management, health information technologies, medical education, and health service research.

To his right is Ms. Rita Reed. She manages and directs all VA budget activities as the Deputy Assistant Secretary for Budget. She is responsible for managing over 68.5 billion under the fiscal year 2005 enacted budget. Ms. Reed has worked on budget issues since she started with VA in 1978.

We also have directly in front of me Mr. Jimmy Norris. He serves as the principal financial advisor to the Under Secretary for Health in his role as Chief Financial Officer of the Veterans' Health Administration and he oversees the budget formulation, justification and execution process of the VHA, as well as the financial management systems.

Over here on our far left is Mr. Arthur Klein. He oversees the actuary's health care demand model and its integration into development of health care policy, impacting VHA as the Director of Policy Analysis and Forecasting Office in VHA's Office of the Assistant Deputy Under Secretary for Health for Policy and Planning.

We also have to the right of Mr. Norris, Mr. John Kokulis.

MR. KOKULIS. Yes.

THE CHAIRMAN. To our right is Mr. Norris.

He serves as the Deputy Assistant Secretary of Defense for Health Budgets and Financial Policy, and is the Chief Financial Officer for the TRICARE management activity.

He is also the principal staff assistant and advisor to the Assistant Secretary of Defense for Health Affairs for all financial policies, programs and activities for the military health system in the Department of Defense. He also provides the medical financial interface between DOD and VA.

To his right -- his left, as I appear to the right -- is Ms. Kathi Patterson. She serves as a principal and consulting actuary for Milliman Incorporated with a background of 19 years in health actuarial experience. She leads this company's practice in research and analysis of veteran data as an expert in actuarial modeling for the veteran population. That is our first panel.

So let me now yield to Mr. Perlin.

STATEMENTS OF THE HON. JONATHAN B. PERLIN, M.D., PH.D., MSHA, FACP, UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS' AFFAIRS; ACCOMPANIED BY RITA A. REED, DEPUTY ASSISTANT SECRETARY FOR BUDGET; JIMMY A. NORRIS, VHA CHIEF FINANCIAL OFFICER; ARTHUR J. KLEIN, DIRECTOR, POLICY AND FORECASTING SERVICE; THE HON. JOHN KOKULIS, DEPUTY ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS FOR HEALTH BUDGETS AND FINANCIAL POLICY, DEPARTMENT OF DEFENSE; KATHI S. PATTERSON, F.S.A, M.A.A.A., SENIOR CONSULTING ACTUARY, MILLIMAN, INC.

STATEMENT OF THE HON. JONATHAN B. PERLIN

DR. PERLIN. Good morning, Mr. Chairman, Ranking Member Evans, members of the Committee.

First, let me start by thanking you for your support to veterans and the VA and the opportunity to be here this morning to discuss the Department of Veterans' Affairs actuarial health care demand model.

Mr. Chairman, I will present a summary of my testimony with your approval and submit my full statement for the record.

THE CHAIRMAN. No objection. So ordered.

DR. PERLIN. Mr. Chairman, the Veterans' Health Care Eligibility Reform Act of 1996 established a uniform package of health care services for enrollees. The legislation also established a priority based enrollment system and required the VA Secretary to annually assess veteran demand for VA health care to determine whether resources are available to provide timely quality care for all enrollees.

In the past VHA budgets were based on historical expenditures and were adjusted for inflation and then increased based on proposed new initiatives. With the implementation of eligibility reform and a shift to ambulatory care, VHA needed to more rationally budget for veteran requirements in the transformed health care system. We also needed to be able to continually adjust budgetary projections for the effects of shifting trends in the veteran population and health care delivery.

As a result, the VA engaged the firm of Milliman, Incorporated to produce actuarial projections of veteran enrollment health care utilization and expenditures. Milliman consults to health insurers and as such is the largest and most respected actuarial firm in providing actuarial health care modeling.

The VHA Enrollee Health Care Demand Model develops estimates of future veteran enrollment and the enrollees' expected utilization for 55 discrete health care services, the costs associated with that utilization. These projections are consolidated and

are available by fiscal year, enrollment priority, age, VISN, market and facility and are provided for a 20-year period.

The actuarial data are then used to support budget planning and future resource requirements. Because of the federal budgeting process, data are used for budget planning approximately 2 to 3 years forward. Of course, the near term projections, such as for the one-year window, are more reliable than further out.

The model provides risk adjustment and reflects enrollees' morbidity, mortality and their changing health care needs as veterans age. Because some enrollees have other health care options, the model reflects how much care enrollees received from the VA health care system versus that of other health care providers. And this concept is knownas VA reliance.

Each year the model is updated with the latest data on enrollment, health care service utilization, and service costs. The methodology and assumptions used in the model are also reviewed to ensure that the model is projecting veteran demand as accurately as possible. VHA and Milliman develop annual plans to improve data inputs on the model and the modeling methodology. On average for the past 3 years, patient projections have been within minus 0.6 percent of actual patients and enrollee projections have been within plus 1.9 percent of actual enrollees. There might be slightly more variants this year, and in a system as large as VA a modest percentage change equates to a very large number of veterans.

Some services the VA provides are not modeled by Milliman. These include readjustment counseling, dental services, the foreign medical program, CHAMPVA, spina bifida and non-veteran medical care. Demand estimates and budgets for these programs are developed by their respective program managers.

Enrollee demand for long-term care services is modeled by VHA. The VHA long-term care model uses utilization rates from nationally recognized surveys adjusted for the characteristics of the enrollee population and known reliance factors to account for such attributes as distance, multiple eligibilities, and case management and then to project demand for both nursing home care and community-based care.

In conclusion, the development of the actuarial model has been an evolutionary process. Future planned improvements include access to data on enrollees' use of Medicaid, TRICARE and the military treatment facilities, as well as the integration of the VHA long-term care modeling into the actuarial model and modeling of additional services such as dental care.

Mr. Chairman, the VHA enrollee health care demand model is a valuable budgeting and planning tool for projecting VHA health care utilization to ensure that VA can provide safe, effective, timely, efficient and compassionate health care to veterans. We combine VA's

substantial experience with a contractor with unrivaled expertise in health care modeling to achieve best actuarial projections possible.

This completes our statement. We would be pleased to answer your questions.

The statement of Dr. Perlin appears on p. 46]

Mr. Miller. [presiding.] Mr. Kokulis.

STATEMENT OF THE HON. JOHN KOKULIS

Mr. Kokulis. Mr. Chairman, and distinguished members of this Committee, I want to thank you for the opportunity to discuss modeling and budgeting for health care costs in the Military Health System. We have three distinct missions in the MHS: First, to deploy a healthy military force; second, to deploy a ready medical force; and third, to manage our beneficiary care through the administration of our TRICARE benefit. In my statement here today I will focus on our forecasting and our modeling of the TRICARE benefit since it makes up the largest portion of our MHS budget.

The Department of Defense offers the TRICARE benefit to approximately 9 million eligible beneficiaries. 19 percent of this population is made up of uniformed services personnel. Their family members make up another 27 percent and retirees and their family members and survivors account for the remaining 54 percent.

TRICARE offers our beneficiaries a variety of options for attaining this health care coverage. Beneficiaries can obtain health care coverage at a military treatment facility, from a civilian provider who is part of our private sector network, or from a certified civilian provider of their choice. Our beneficiaries can also obtain their prescriptions through our MTFs, through retail outlets or through our TRICARE mail order pharmacy.

The challenges we face as we prepare our annual budget requests include predicting how many of our eligible beneficiaries will use the TRICARE benefit, what options they will select, how often they will require care and prescriptions, what inflation rates will impact on procurement of services, and the impact of recently enacted changes in benefits.

In developing projected trends for these underlying care costs our analysis includes consideration of the following: An actuarial forecast of our population for the coming year; second, recent trends in our contractors' health care costs due to the attraction of new users, volume trends and inflation; third, recent and projected trends in private sector health plans and the national health care sector in general; and fourth, effects and changes in the TRICARE program itself, such as benefit changes, changes in provider reimbursement policies and contract transitions.

Using our claims database, we then decompose the historical trends in these underlying health care costs to determine what factors would be ongoing versus one-time events. These factors includes the global war on terrorism, changes in the number of TRICARE eligibles under the age of 65, changes in the percentage of that group who actually use TRICARE, and changes in the cost per user, including changes in unit costs and the volume of services per user.

In addition, we assess the forecast growth in pharmacy, both for increase in users and increase in unit price. These methodologies enable us to construct a forecast for our expenditures for the coming year.

Given the growth and volatilities of these expenditures our department is engaged in the continuous effort to reduce our costs and improve the predictability of our obligations. These activities have included: One, a consolidation and realignment of the TRICARE health care regions from 12 regions down to three, allowing us a more streamlined administration of those plans and enhanced portability for our beneficiaries; second, a movement to performance based budgeting for our MTFs with a phased implementation of a new prospective budgeting approach. We intend to base MTF budgets on workload output such as hospital admissions and clinic visits rather than relying on historical resource levels such as number of staff employed, supply costs and other materials. Once fully implemented, prospective payment should allow us for better management performance at our MTFs.

And third, the redesign of our pharmacy program into a single integrated program allowing us to more effectively manage this effort. We are also standardizing formulary management and are promoting the use of more cost effective products and points of service.

In addition to these and other activities, we are also actively working with the Department of Veterans' Affairs where we can share resources to increase access, improve quality and more efficiently deliver the health care benefit to our beneficiaries. We currently have 12 projects being funded this year from our joint DOD-VA intensive fund.

In summary, the Military Health System has many factors that drive its annual expenditures. The Department has made progress in our efforts to better forecast and control these expenditures and will continue these efforts in the future. There is more work to be done. Through it all we will continue to focus on job one, which is to appropriately fund our medical readiness requirement and to provide exceptional care to our active duty personnel, their families and our retirees who have sacrificed so much for our country.

Thank you, Mr. Chairman, for inviting me here today, and at your convenience I will be happy to respond to your questions.

[The statement of Mr. Kokulis appears on p. 56]

THE CHAIRMAN. [presiding.] Thank you very much. I don't know the answer to this. I just have to ask, with regard to your budgets, when we did one of the supplementals did you participate, did DOD Health participate in one of the supplementals we sent over to the VA for 2005? For the 2005 supplemental, did you give monies out on supplemental?

MR. KOKULIS. Yes, we did.

THE CHAIRMAN. Do you remember in what amount?

MR. KOKULIS. I want to say it was approximately $680 Million.

THE CHAIRMAN. 680 million.

MR. KOKULIS. Yes, for the GWOT supplemental.

THE CHAIRMAN. Now you are transitioning to a performance based budgetary methodology?

MR. KOKULIS. Yes.

THE CHAIRMAN. And your provider methodology was more demand?

MR. KOKULIS. It was more based on what is your historical cost.

THE CHAIRMAN. Trends, simplify it.

MR. KOKULIS. And now we are actually saying okay, what workload are you doing in terms of number of visits, hospital visits, number of clinic visits, and then taking a reimbursement rate based on the private sector and then reimbursing the MTFs for those visits versus paying them on a historical average.

THE CHAIRMAN. So the VA and their model, do you have any knowledge about their modeling? Just basically what you know.

MR. KOKULIS. No. I joined the DOD in April so I am busy ramping up on my own.

THE CHAIRMAN. Have you read Dr. Perlin's testimony?

MR. KOKULIS. I have not.

THE CHAIRMAN. Your model, is it a one year?

MR. KOKULIS. No. We actually go out many years. It is like Dr. Perlin says, a 3-year look in terms of our obligation.

THE CHAIRMAN. This is two and a half?

MR. KOKULIS. Yes, but basically when you get into -- the key to our whole modeling is that actuarial forecast of your population, and that is really where you got the granularity so that you can have some numbers that you can have some confidence in, and that is really a 12-month look.

THE CHAIRMAN. Ms. Patterson, the private sector is what you use for your model?

MR. KOKULIS. Private sector. You do your 3-year plan or --

THE CHAIRMAN. Ms. Patterson.

MR. KOKULIS. I am sorry.

[The statement of Ms. Patterson appears on p. 69]

MS. PATTERSON. I am sorry. It is more typical to budget out for one year rather than 3 or 5 or 10.

THE CHAIRMAN. Your company does budget contracting for a lot of the private health systems in the country, does it not?

MS. PATTERSON. That is correct.

THE CHAIRMAN. So in the private sector when it comes to for profit, they are doing it for one year. So DOD is doing a 3-year model and VA is doing a two and a half year model?

DR. PERLIN. Two and a half to 3-year window.

THE CHAIRMAN. Two and a half to 3 window, all right.

With regard to DOD's budget, you participated in this supplemental in 2005?

MR. KOKULIS. Yes.

THE CHAIRMAN. Did you participate in the supplemental in 2004 and in 2003?

MR. KOKULIS. I will have to take that for the record and get back to you. I am not sure.

[The information follows: Yes. In 2004 we received $658 million and in 2003 we received $596 million.]

THE CHAIRMAN. I know that that operations, OIF, OEF, are having some strains on your system, are they not?

MR. KOKULIS. They are definitely.

THE CHAIRMAN. And so 680 was your bogey that we have to plus up?

MR. KOKULIS. Yes.

THE CHAIRMAN. Any other with regard to your modeling in your trends and forecasts or methodologies; as you move to this new model, were their errors or corrections or things that you needed to do for better forecasting? Because we already gave you, we passed your 2006 budget. So are you in a little more comfort?

MR. KOKULIS. There are always things that pop up such as emerging requirements, whether it be all of a sudden we need a Tamiflu vaccine for avian flu virus. And that is an emerging requirement that has to be funded and we have to find offsets. But as far as the implementation of prospective payment, we are in its infancy and as we roll it out and do lessons learned on ourselves what we are finding in the initial round is we did a poor job on incorporating readiness.

We have a dual mission. We have the regular health care mission, and then you have readiness. So we get into what is the cost of readiness and how do you reimburse the MTFs for things they are doing to prepare the troops as they get prepared for battle. So we need to do a better job there.

THE CHAIRMAN. So Dr. Perlin, now that we recognize that the military health delivery system was short about 680 million covered in the supplemental appropriations, in practical terms, if OIF and OEF

contribute to actuarial and budgetary challenges for fiscal year 2005 or 2006 within DOD, it has got to be there for you too.

Can you please comment on OIF, OEF's challenges with regard to what it is doing to your budget forecasting.

DR. PERLIN. Sure. First, we are proud, privileged to take care of our U.S. Combat veterans. In the last few years we are aware, as we testified, in a recent period of seamless transition that as of -- in April we were aware of 360,674 separated from service in that period. Of that, as of in April, about 85,857 had presented for care in VA. Most of them are the issues of the younger generation, and another 17,274, so together in excess of 100,000, that 17,000 had presented to our Veterans Readjustment Counseling Center. Two and a half to three and a half years ago when this budget was formulated, there would have been no way to predict that these combat veterans would have come to VA.

THE CHAIRMAN. Let's break it out. Part of the medical services that you are providing for them, part of this surge in utilization is coming from what?

DR. PERLIN. Sir, it ranges the spectrum. Unfortunately, the majority of young men and women coming to us come with the issues and illness of that age. We are prepared for and have taken care of additional mental health care needs and there are a number who are grievously injured and that we provide very intensive care, rehabilitation to those.

THE CHAIRMAN. And is it not true there is a trend with DOD right now, saying with regard to guardsmen and reservists, that see, Congress has said, "Tell you what, we will open up the VA, we will take care of these guardsmen and reservists and give them access to the VA." We recognize that was in not in your budgeting forecast, okay. But with regard to dental, what is happening?

DR. PERLIN. Well, we are working together with DOD. It is very close collaboration. But there is a difference between dental health, which VA is helping to restore, and operational readiness. In the area of dental we have collectively identified a number of $90 million of unanticipated dental health care needs in this alone.

THE CHAIRMAN. If you have identified 90 million that you didn't anticipate with regard to dental and you have got this surge in medical utilization from these other soldiers that are now accessing your system, have you been able to put a number on that?

DR. PERLIN. We are working on identifying a number, but obviously we are using additional resources that we didn't anticipate at the time that we budgeted two and a half years ago.

THE CHAIRMAN. I know, my colleagues, I have exceeded my time. If I could go for two more questions, because I think we are getting close here.

With regard to your forecasting, you are two and a half years out,

you have some challenges today that were not anticipated. Does the VA usually do a midyear review? Do you not?

DR. PERLIN. Yes, sir we do.

THE CHAIRMAN. With regard to your budgets, you make sure how you are going to do right?

DR. PERLIN. Yes, sir.

THE CHAIRMAN. Congress, authorizes DOD to be able to have a carryover, right?

MR. KOKULIS. Yes, 2 percent.

THE CHAIRMAN. What do you carry over?

MR. KOKULIS. Two percent.

THE CHAIRMAN. Two percent, which is actually 400-plus million?

MR. KOKULIS. 298 million this year.

THE CHAIRMAN. Normally it will carry over?

MR. KOKULIS. For next year it will be approximately 350 million, so close to your 400 million.

THE CHAIRMAN. What is your normal carryover, Dr. Perlin?

DR. PERLIN. 2006 we had anticipated bringing forward $482 million. At this point we have assessed and we think it will be closer to 75, perhaps as low as 50 in that particular account.

THE CHAIRMAN. Because of some --

DR. PERLIN. Unanticipated increased utilization has committed us, unanticipated by the actual model, increased health care associated in part with new combat veterans coming to us for service, as well as unanticipated increase because of projections that weren't on the mark from the actuarial model required us to use resources that at the point of budgeting had been intended to carry forward and, to be fair, we are bringing all resources to make sure that we can provide timely and effective care to veterans. That is going beyond their budget projections for 2005 as well.

THE CHAIRMAN. Can I keep going for a second?

How far off do you believe you may be from, you know, the contracted model that you have to where we are potentially right now?

DR. PERLIN. Right. Well, this is the most rational and effective way to predict. I think we have to realize that we are pushing the performance envelope on this model. As Ms. Patterson said, it is at its best when one projects in the immediate year ahead, because with the Federal budgeting process we are projecting two and a half to three and a half years ahead, and in fact the plan was for 2.3 percent growth and the actual growth is 5.2 percent. And that is at 2.9 increase, annualized. We have had some months this year where we are headed further to 3.4 percent ahead. I know 3.4 percent sounds pretty darn good on an actuarial model, and it is, but that small number translates into a very large number of veterans.

THE CHAIRMAN. A large number of veterans, large with regard to projected dollars. You know, if you project this out between now and

the beginning of the next fiscal year, you are going to have to be moving some monies around in order to maintain the quality of care and the access of care to those veterans. So you are going to have to be moving some funds, are you not?

Dr. Perlin. That is correct.

The Chairman. And you know about how much or from what sources you are going to be able to do that?

Dr. Perlin. Right, in addition to using resources which had been intended to be carryover, we have used some of the funds associated with capital, of nonrecurring maintenance. Now I do need to tell you that after 4 years of very robust support by the administration we have invested in the infrastructure, but this year we are using some of those capital dollars to make sure that we provide timely care to the veterans who are coming to us.

The Chairman. Right now based on your testimony, if we take about 80 on dental and you talk about the carryover, around 350, we are approaching half a billion.

Are there some other challenges out there that we don't know about with regard to getting to the fiscal year end, maybe a surge from 7s and 8s or something else?

Dr. Perlin. There appears to be increased utilization among -- you referred to the concept of ghost users. What we have, the patients who use the system and the enrollees there appears to be very instrumental as well in terms of the relationship of patients to enrollees, with greater utilization there as well.

The Chairman. And are you able to give a projection dollar figure that you are going to have to use from potential capital accounts, as you indicated?

Dr. Perlin. We are still working on the final number but it could be as high as $600 million.

The Chairman. I can do pretty easy math. That is a billion dollars.

Dr. Perlin. Yes, sir.

The Chairman. So can I go one more? Can I keep going for a second?

Congratulations on your new job. You have a tremendous challenge in front of you. We have a challenge also. We have a model, and we do everything we can to address forecasting, assumptions, actuarial data, morbidity, utilization, you name it. On top of that, we are engaged in a global war on terror and so we also are taking care of soldiers who are coming back, plus we have an increase in utilization by our veterans of the past, which causes a variance in your present budget in a model that has pressed the boundary of its forecast. Am I close, Ms. Patterson?

Ms. Patterson. Actually you would press the boundaries of any forecasting model to go out 3 years.

THE CHAIRMAN. This is already constructive. Last one, and I am going to yield, unless you have something off of what I just said.

MS. HERSETH. Thank you, Mr. Chairman. I would like to get this question before I have to leave momentarily because I think it goes along the line of questioning you are pursuing and a comment you made at the beginning, and that is how you are integrating base realignment and closure rounds into the model? Because I just came from Ellsworth Air Force Base, which is on there currently, and if we have people that work in that area that may lose their employee sponsored coverage because of businesses that are affected, then they are seeking access to the VA system as we have seen in other parts of the country whether it is a BRAC closure or a closure of a mill or what have you.

Has that been incorporated? I think the Chairman mentioned in the past there has been a concern about whether or not a BRAC was incorporated in the model, and if you are looking two and a half to three and a half years out is this another anticipated cost we could be seeing, maybe not this year's end because the closures won't happen for about another 2 years?

DR. PERLIN. I would ask our Art Klein to elaborate on how the model incorporates such actions as potential realignments under base realignment economies.

MR. KLEIN. We know it is going to take time, especially when some of these construction actions are going to take place, and what we are doing is planning to include that into our actuary model in the future.

THE CHAIRMAN. Before I am going to yield to Mr. Evans, it appears we have some tremendous challenges in front of us, the Committee, with regard to oversight. We are going to continue to get into how you do your methodology and your forecasting. At the same time we now realize that you have a tremendous challenge in meeting the present need and requirements, and that you have money and you are about to move around accounts. We are going to need to learn and understand more about how you are going to be moving monies to meet particular needs and what effect that is going to have if you have this shortfall of approximately 1 billion in 2005.

I yield to Mr. Evans.

MR. EVANS. Thank you, Mr. Chairman. I would like to yield my time to the gentlemen from Wisconsin, Mr. Michaud.

THE CHAIRMAN. No objection.

MR. MICHAUD. Thank you, Mr. Chairman, and Ranking Member Evans. I have got a couple sets of questions.

Early in the process, the VA must estimate the funding gap it will be faced with. What is the, what does it attempt to do, you know, to close that gap? At what point in time does the ideal model become affected by nonhealth care considerations? Second part of that question

is, when are we essentially modeling to fit predetermined outcomes and not modeling based on health care and patient requirements?

Those are my first two questions. The next two relate to an article on Tuesday in the Washington Post which was entitled Health Care Costs Spending Up: More Middle Class Could Join Ranks of Uninsured. The article points out that spending for those with private insurance rose 8.2 percent in 2004. The medical cost growth has outstripped the growth in wages, and that 45 million Americans, nearly 50 percent of our population, are uninsured and many veterans who previously relied on their health care insurance are now turning to the VA. And voicing similar concerns to Congresswoman Herseth and the Chair, how are the effects of growing numbers of uninsured accounted for in the models? And it is not only the BRAC process which will definitely affect but all the number of job losses. How does that affect, the outside factors in the model?

DR. PERLIN. Thank you, Mr. Michaud, for the question. I think I will divide it into a couple of parts, your first and second comments. The model runs independently. It factors in the transient health utilization and secular and environmental trends in terms of the health services delivery and use of health insurance for anything else that may be going on in the environment.

In terms of how these things are factored in, I would defer to the actuary who really is most knowledgeable about describing that aspect in the operation of the model.

MS. PATTERSON. The model has two components that can address that. One is we project enrollment into the VA health care system, and once those veterans have enrolled then we project their health care needs. Dr. Perlin addressed the trend rates that we employ in the model to address some of the health care changes over time, anticipated health care changes over time. With respect to enrollment, if in fact there is an increase in the unemployment rate in particular areas and what not, that would need to be handled within the enrollment projections and we base enrollment projections on historical trends.

We have what we call priority transition within the model which also takes into account -- just one tiny example of this transition is Priority 7 and Priority 8 veterans transitioning into Priority 5 veterans. So those would be the poorer of the nonservice connected disabled veterans. And so it takes it into account in many different aspects.

It also has the functionality to actually measure the impact of a potential major downturn in the economy and such. We have not modeled that to date, but it does have the capability of doing that the way it is set up.

MR. MICHAUD. If I might follow up, Mr. Chairman, that is a good point. You are using averages in models. What really concerns me is

we have heard a lot of -- particularly in the last year, in the election year, how well the economy is going around the country. But that might not be necessarily factual in certain regions. And that is my big concern because we have had labor markets in Maine whose unemployment rate was as high as 35 percent. Particularly when you look at Maine, 16 percent of our population are veterans. We have a high number who are in the Guard and Reserve who have been over in Iraq and Afghanistan.

So that is why I am requesting the overall model and assumptions, how accurate is that model when you look at the unemployment rate particularly in separate regions of the country.

MS. PATTERSON. Right, and we can address that and yes, it does use historical data to develop some of the future assumptions. But our enrollment assumptions are at the sector level, they are not at the county level. We have something we called sectors which are groupings of counties and for the most part large counties become a sector but some of the rural counties that are quite small are grouped into sectors. But we do calculate enrollment rates at that detailed level and by three different age bands, so that hopefully if there has been a chronic unemployment issue in a particular area that will be reflected in the enrollments rates. If there is something that is happening or expected to happen in the future, if we are made aware of that, we can certainly model that in the current modeling program.

MR. MICHAUD. And Dr. Perlin, the second part of that question is, at what point in time do you throw out the model and your budget request is primarily driven by monetary aspects in --

DR. PERLIN. The model comes forth intact, and basically in any given year it will be development of new policy initiatives. I believe they are pretty transparent though we had vigorous debate and discussion of some of the policy initiatives that came forward in the year. So the model comes forward intact.

MR. MICHAUD. So in other words the budget that the VA requested to the administration reflects what the model actually impacts and it is not inaccurate so, in other words, does the VA disagree with the Independent Budget as far as the assumptions put together in the Independent Budget?

DR. PERLIN. In general, the model comes forward and then there are policy initiatives, as I mentioned, and then perhaps other assumptions, such as efficiencies, that constitute the entirety of the overall budget that is presented.

MR. MICHAUD. If I may, one other question, Mr. Chairman.

You had mentioned using capital funds, which might be good for the short-term. -- two-part question. I guess my concern is, even though you are using capital funds to meet your current needs now, which is strained, what long-term effect will that have on the budget, whether it is cost-effective?

The other concern is, and I can tell you, using Togus hospital in Maine, the Togus facilities had to put up scaffolding over the doors to block bricks from falling on patients or staff. It is a big concern of mine, shifting money around like that. Have you done analysis on the long term -- actually increase the budget of the VA by taking away those capital dollars?

DR. PERLIN. Thanks for the question.

We appreciate the robust support that the VA budget has had over the last 4 years which has allowed us to invest in a number of capital areas. We recognize this is a short-term strategy. The short-term strategy ensures, between that and using the carryover, we have enough resources to care for veterans this year. It is not viable in perpetuity not to invest in the infrastructure. Sooner or later, you have to make that investment. And the things that are curtailed first are -- those things are, first cut, cosmetic; deeper cuts, modernization, remodeling.

THE CHAIRMAN. Thank you.

Before I yield to Mr. Bilirakis, I have to correct a statement prior to my yielding to Mr. Evans when I referred to this billion dollar challenge for '05, or as I call it, a shortfall. I am trying to figure out what you have for '06, not for '05. You have monies that you are utilizing for a workaround, moving dollars from your capital accounts and using a cushion account. But we just passed a budget with regard to '06 and an appropriation that gave you an additional billion over and above what the President had requested. We are going to have to get in here and figure out how we need to help you with regard to your '06.

I yield now to Mr. Bilirakis.

MR. BILIRAKIS. Thank you, Mr. Chairman.

Ms. Patterson, you have been assigned by Milliman to VA since 1996.

MS. PATTERSON. I didn't work directly for VA back in 1996, but I was involved in the first discussions of a new model.

MR. BILIRAKIS. You also do private work, I mean, other than the VA, private firms?

MS. PATTERSON. Yes, but my major other clients are Medicaid, either States or health plans.

MR. BILIRAKIS. All government. You have done actuary work for private clients?

MS. PATTERSON. Yes, I have.

MR. BILIRAKIS. What was the age of the data that you used for those private clients?

MS. PATTERSON. For private sector, depending on whether we are using our health cost guidelines from our firm or whether we are using some of the client's actual data, it is usually as most current as it can be. We have something called lag or run-out where you make

sure your claims data is complete and the providers have had time to actually get it submitted, paid and into the system. But using the most recent year of data is incorporated into any modeling effort.

MR. BILIRAKIS. Most recent year --

MS. PATTERSON. Six-month to a nine-month lag.

MR. BILIRAKIS. What is your opinion about the fact that VA uses 2-plus-year-old data?

MS. PATTERSON. I guess in consideration of the fact that you need to budget out that far, you don't really have a choice.

MR. BILIRAKIS. You are budgeting out that far ahead. I am talking about using old data.

MS. PATTERSON. We are using the most recent projection for fiscal YEAR 2004.

MR. BILIRAKIS. For 2007?

MS. PATTERSON. Yes, that is the most complete data at the time we do the modeling; and that is very consistent with what is done in the private sector. It is just they would be budgeting for a more current period.

MR. BILIRAKIS. This $1 billion that has been talked about, this shortfall, call it what we will, which is being made up for on an internal basis, as the good doctor explained, that is the result of what, in your opinion? It is not bad actuarial figures on your part, right?

MS. PATTERSON. I don't know that is an appropriate question for me, but I will go with it.

My opinion is that the model forecasts as well as the data that goes into it, I think some of the things that have occurred over the past year or so were not reflected in the model because they occurred in the last year or so and they weren't anticipated. The biggest miss is simply due to the fact the assumptions going forward did not hold true.

MR. BILIRAKIS. I would ask, I guess, both you and Dr. Perlin, based on this current history, $1 billion shortfall, is that the result of a reasonable error that nobody could do anything about or is that the result of lack of efficiency or whatever the case might be? But your request for next year, 2006, and the bill is already at the Senate, is it already off by at least that $1 billion?

DR. PERLIN. Sir, I think if your summation of that --

MR. BILIRAKIS. I don't know if it is a good summation.

DR. PERLIN. The statement you make, has the use of resources in 2005 affected the budget assumptions going into 2006? And I think it is absolutely fair to say that it has. We had intended to carry over more than we would be able to, but --

MR. BILIRAKIS. You talked about the capital in responding to Mr. Michaud. You talked about using capital dollars. So those capital dollars, assuming they are needed dollars, will now have to be made up for in '06, but that is already past us now unless the Senate can

do something with it. It might even carry over to ‘07. Are we robbing Peter to pay Paul?

Dr. Perlin. The investments in infrastructure will eventually have to be made.

Mr. Bilirakis. They have to be made up somewhere along the line.

Dr. Perlin. The resources are there to assure the care for veterans in 2005. It doesn’t factor 2006.

Mr. Bilirakis. I appreciate the fact that resources are there for 2005; and, based on the question here, we were satisfied that that is the case. But we have 2006 ahead of us, and that is being compounded by virtue of the fact that some of the resources used in 2005 for this purpose were intended to be used for another purpose.

I am just going to ask one quick question, and this is the fastest 5 minutes I have ever experienced. But, Ms. Patterson, are you getting complete cooperation from the VA in terms of your advice to them and whatnot?

Ms. Patterson. Yes, they provide any data I request. They provide experts when I need additional information.

Mr. Bilirakis. Are they using the data that you recommend to them, the actuarial data that you recommend to them?

Ms. Patterson. I can’t attest to that. I provide it, and that is as far as I go.

The Chairman. Mr. Udall.

Mr. Udall. Thank you, Mr. Chairman.

I guess my first question is for Mr. Perlin and Mr. Kokulis. How is the VA making sure that returning soldiers are being put into these models and how are you ensuring that they are accurately projected and that they provide the needed resources for these new veterans as they come into the VA health care system?

Dr. Perlin. Thank you, Mr. Udall, for that question.

The Secretary has made an absolute commitment that new combat veterans receive priority and accessing care in our system. Let me assure you, with the good partnership with the Department of Defense, we have more awareness than ever in terms of meeting the clinical needs of new veterans. They send us rosters to help us identify these new veterans; and, in fact, when a veteran needs care at a military treatment facility, we have social workers and they have uniformed personnel placed in military treatment facilities and VA hospitals.

To the point of your question, 2-1/2 to 3-1/2 years ago, the budgeting couldn’t anticipate these current numbers with the numbers that we are now commenting on. These veterans have come to us with their eligibility following combat service. That is being incorporated into the model going forward.

Mr. Udall. Let me just follow up on that. What you are saying is 2-1/2 to 3 years ago, because this was a new situation, having as

many troops in combat as we had, it was a very unpredictable situation, how many injuries you would get, the kinds of things that you would see, now, having a more stable kind of situation, you are able to predict? Is that a fair characterization what you are saying?

Dr. Perlin. Previously, we used separation data, and we got that periodically in 2001 because the trends of separation were fairly constant. With the increased OPTEMPO and veterans who have unique eligibility by virtue of combat service, they have 2 years of eligibility, and we welcome those veterans, that couldn't have been anticipated 2-1/2 to 3-1/2 years ago. It is to the best we could incorporate it. But 2005 predicts for 2008; 2004 for 2007.

Mr. Kokulis. The only thing I could add to of Dr. Perlin's comments would be it really gets into that first snapshot you take in the beginning of your fiscal year with regard to your population. Rather than using a static snapshot of where everybody is, you really need to take that actuarial look that estimates where people are going to be based on deployments, expected major movements in retirement, et cetera, to get the best idea where everybody is going to be, so when you do put that forecast in place with that population, you can appropriate the money in the right places for those people.

Dr. Perlin's comment that partnership between DOD and VA works well in that sharing of information, for the DOD specifically where our forecast is challenged is in the whole TRICARE benefit. Discussions a little bit earlier about as retirements come in and where do people get their health care, our ability to forecast the take rate for these people who are eligible for TRICARE and those who decide to keep their own private insurance has been the tougher part. The actual care for the active duty and then going to the VA we feel we have a good handle on it. That take rate for that retiree group, you know, the under 65 retired or over 65 retired, is where we find our biggest challenge.

Mr. Udall. I am shifting direction a little bit here. One of the big problems that I see is Congress passing laws and requiring that health care be given to veterans and then we give discretion to the Department to create priorities and categories and all of that. Clearly, we have this big debate about Category 7 and 8 and the different kind of care that different veterans get. I think many of us on this Committee would like to see the Congress fully fund health care for all veterans, and there have been bills to that effect. When you do your modeling, could you tell us what it would cost in terms of dollars to not have these kinds of categories in various priorities and say we are going to make sure that all veterans have the kind of health care they need? What kind of numbers would we be looking at?

That is what the next panel tries to do, I think, when they look at an Independent Budget. They are not looking at the constraints the various departments have. They are looking at what kind of dollars

are you going to put into the system to make sure that every veteran gets health care -- adequate health care in a timely way and that is quality health care.

Dr. Perlin. Congressman, that is really the point of the model, the ability to predict the utilization, be it by category or disease or condition, exactly what resources are needed to provide safe, timely, effective, efficient, compassionate care for the veteran. And I defer to the actuary for any elaboration, because we do believe it is a useful tool, albeit this year we pushed the performance envelope in terms of the lag time and missed the mark by about --

Ms. Patterson. The model itself has the capabilities of estimating the impact of many policy decisions. And one -- if you are going to open up the system even more, we can estimate the impact of that and the actual dollars associated with opening the doors even wider and maybe even enticing more veterans to enroll and seek health care. It is absolutely in the realm of an eligible projection.

Mr. Udall. I see my time is out, and I appreciate that very much.

The Chairman. There is a vote on the rule. I intend to stay here and keep this going.

Mr. Brown.

Mr. Brown of South Carolina. Mr. Chairman, just one question. I noticed in our discussion that the Department of Defense really acknowledged they were having a shortfall in their health care and asked for some money in the supplemental. And I was -- my question goes to Dr. Perlin. Did you not all sense that or did you not have the opportunity to do the same?

Dr. Perlin. Thank you, Congressman Brown, for that question.

When we look at the utilization numbers, the number of veterans requiring care every month, through February things were looking pretty on target. Actually, in the months -- really, in April began to ramp up and see more increase against utilization.

As mentioned earlier, thanks to the robust support in the past years going into this year and because of being fairly much on target, we felt that and still do believe we have the resources for this year, 2005. It has been discussed, and it does predict some challenges in 2006.

Mr. Brown of South Carolina. If I might follow up on that.

I notice the -- is there some kind of a trend that maybe the enlisted personnel is not re-upping as regular -- are we getting more folks leaving the service earlier that might be shifting more of the costs to the VA that if they stayed in service their health care would be funded by DOD? Is there any trend in that direction?

Mr. Kokulis. I will take that for the record.

[The information provided is as follows: No Active duty enlisted retention remains strong. We anticipate that the Army and Marine Corps meet or exceed FY 2005 retention goals. Navy and Air Force retention is sound although below historical averages -- a deliberate

response as both Services reduce their end strength by retraining and converting members from overmanned skills to undermanned skills to balance their forces. The bottom line is that DoD enlisted retention is very sound and we are retaining the right mix of quality members.]

I can't speak of any trend that I have seen. To reiterate, the trend we have seen is, in the enlisted population, the actuarial analysis and the estimates tend to be rather consistent with what we modeled. It is that retired over 65 and under 65 and the take rates that end up surprising us on any given forecasting period.

Mr. Brown of South Carolina. Just one follow-up question then. Is there any -- in the trend model, is the projected amount of money coming from third-party pay? Is that on target or is there a shortfall in that projection?

Mr. Kokulis. I guess the best way to answer, it is never where you want it to be. We have some targets, and we continue our efforts, but there is a lot more we can do, and we are always looking for good ideas whether it is in-house, whether it is working with contractors. I know the Navy does both in-house and contracts out for third-party collections. The Air Force is 100 percent contracted out, and the Army does its own in house. So everybody is looking for best practices in trying to up it and increase our third-party collections.

Mr. Brown of South Carolina. Thank you for coming and being part of this discussion and helping us work through a tough situation.

The Chairman. I don't know how well prepared, Dr. Perlin, you are to put some dollars on this, but I am trying to understand this a little bit better. So as we go into the '05 budget, that was sort of laid out in '03?

Dr. Perlin. '05, based on '02 data.

The Chairman. Based on '02 data for '05.

Dr. Perlin. That is right.

The Chairman. And in '02 data, I am trying to figure out what is the variance to come up with this present-day challenge that you have to face and you have to move funds around? So outside OIF, OEF, dental, cat 7s and 8s utilization, what else was there? Pharmaceutical? Or is that part of the utilization costs?

Dr. Perlin. We have tried to anticipate the pharmaceutical growth. We have made efficiencies in pharmaceutical utilization, but we continue to push for those efficiencies, and they have gotten harder. Once you have gone from equally effective drugs to ones that are equally effective but less expensive, there is no more there. We are pushing in that regard. Mr. Kokulis mentioned the avian flu, unanticipated.

The Chairman. The what?

Dr. Perlin. Mr. Kokulis from the Department of Defense gave an

example of a completely unanticipated contingency. As you know, people have concerns about the avian flu being a world pandemic and with our population, particularly with a lot of older and chronically ill veterans, we had to expend $25 million to make sure we had adequate storage of this treatment for that avian flu.

THE CHAIRMAN. Tsunami wasn't in yours either, and that was a large cost.

With regard to medical inflation, the medical inflation data was input from '02, and then what happened in '05, how were we off? Not off?

MR. KLEIN. The model certainly looks at the health care industry trends, and Milliman has a very robust price trending that they use. Obviously, it is looking at historical, but it does go out into the future, too. If '02 was the time frame for which actual data was available for the budget, the actuary would come forward to VA and bring in their price trend experts and we would discuss which of those trends and utilizations are related to VA and then we would resolve and agree to the price trending for the future. That is incorporated in the model every year, and we update that annually.

THE CHAIRMAN. Is this a work product that belongs to your company that others utilize or do you rely on data input from someone else?

MS. PATTERSON. We have certain experts within the firm who every year update some of our tools that are strictly for measuring health care cost trends. They are involved in these meetings, and they fully understand the health care trends and what moves them in different directions and why and when. Those discussions are held with many folks at VHA to determine which ones are applicable to the VA health care systems and which ones are not.

For instance, typical provider discounts aren't typically applicable in the VHA, and so we know to remove the impacts of those. The actual research that goes into these products are used by private sector and other government entities, but we do modify it for VHA.

THE CHAIRMAN. Let us get into your last statement on the modification for VHA. Over the last 5 years, would you be able to tell me what numbers you utilized in the private sector, if they range from 9 to 16 percent? Is that about right?

MS. PATTERSON. I would not be able to give you a number for that, no.

THE CHAIRMAN. Am I close when I say between 9 and 16 percent?

MS. PATTERSON. It depends. When you are looking at a full, comprehensive health care package, trends can be deceiving, because each benefit package can generate a different trend.

I apologize for not being able to answer.

THE CHAIRMAN. Let me ask you this, why pick a number? Let us say that you call it the health care cost index.

MS. PATTERSON. That is what our product is called, yes.

THE CHAIRMAN. Let us say, for example, hypothetical, it is 8 percent next year. You come up with a different number with regard to what you put in the model for VHA. Why?

MS. PATTERSON. Why?

THE CHAIRMAN. Why do we use a different number for VHA?

MS. PATTERSON. Well, for one thing, we don't use a single number. We use many different trend rates for different things. We have a utilization trend rate, we have an inflationary trend rate, we have an intensity trend rate, and they all differ by type of service. When you say 8 percent, that could be 8 percent inflation and intensity trends for pharmacy. We look at that and say the pharmacy trends in the private sector are going up by X amount. But in VA you have much more price control -- VA is a huge purchaser of prescription drugs, so they have a lot of buying power. So that is dampened and we want to reflect that and we don't want it to skyrocket like the private sector.

THE CHAIRMAN. Are you comfortable with regard to the calculation of that number that is utilized within the model?

MS. PATTERSON. Yes, I am, sir.

DR. PERLIN. Mr. Chairman, forgive me, but the follow-up -- we are having an internal discussion, and I think we can flesh out the question you asked a little bit better. You asked what other sorts of things can vary, and let me give you some examples.

In terms of building off of what we have been discussing, the increased utilization by veterans in this current year, that has the effect not only of producing health care costs for the care of those individuals but caring for additional staff on board; and that is an additional and unanticipated expense.

There are other items that are outside the actuarial model. The actuarial model accounts for 87 percent of the clinical budget, and some of those areas are also inflating. One is a program, CHAMPVA, which is the program for 100 percent service-connected veterans' families, dependents or the families and dependents of deceased 100 percent service-connected veterans; and those expenditures increase as well.

Not in the actuarial model is the long-term care, and we have had robust discussion about long-term care with this Committee previously. But, as everyone is aware, that is a very important area, an area we are trying to extend our dollars by serving veterans in the community to an even greater extent; and there are some assumptions that we think are overly ambitious. I note that there have been reports about what possibilities there might be in contracting care as a new example. But some of those are extremely ambitious; and, in an aggregate, that really is what generates the challenges we are discussing.

THE CHAIRMAN. I guess what I am going to try to do here -- I am going to take all of your testimony and take the statements and be

a very good student and get the input also from my colleagues and staff with regard to the model itself, looking at, yes, how Congress also does its budgeting processes, recognizing that, understandably, that DOD wants to go to a more predictable model. So I am going to be sensitive to why you made these judgments and decisions. At the same time, I am going to say, are there lessons learned that can be applicable here; and, hopefully, you two can have those discussions --

DR. PERLIN. By all means.

THE CHAIRMAN. -- so we can have some better predictability. Because I am tortured here that we have passed recently an 2006 budget that came to us from the administration. Even though we plussed it up $1 billion, I now don't know what the right number is supposed to be for 2006. So we have to carry on discussions with regard to these trends.

And you mentioned about these risk adjustments. So somewhere in here that even though you are pressing the bounds or going to the horizon on these projections, there really is, we call it the nebulous, that risk adjustment area. It is that gut check at the end of what are the possibilities or the potentials that we missed, you missed, right? And these things just weren't calculated. Congress has to be responsive; and that is where we want to work with you with regard to these '06 numbers.

Be watchful and good listeners with regard to workaround and with regard to its impact in the system and, as I just heard you say in your testimony, to maintaining the quality of care.

Obviously, there will be an interest with regard to access also, recognizing that Congress set up the prioritization with regard to access of care. I know in your testimony the first words out of your mouth were, we are taking care of those men and women coming back.

I want to thank all of you for coming. This is very constructive, what you have done here today. You have been very helpful, and we are going to continue with regard to the actual science of this. It is hard. It is difficult. You have an expertise, I am appreciative. We are going to need that.

Please don't become so defensive of the model. Allow us to figure out how we use this model from the private sector and how to best forecast with regard to our budgets and predictability, recognizing now, today, that we are pressing the limits of your model, correct?

MS. PATTERSON. That is correct, of any model.

THE CHAIRMAN. Especially the one we care about is the veterans piece and equally the DOD piece.

I want to thank you.

The second panel let me do by way of an introduction, and then I have to exit, and hopefully I can make it back. If any of you can stay, that is wonderful. If you can't, if you could have some of your staff

stay, it would be wonderful.

The second panel is:

Mr. Steve Robertson. He serves as Director of the National Legislative Commission of the American Legion. Prior to joining the American Legion, Mr. Robertson served as Disabled Veterans Program Specialist for the Job Service, North Dakota, and as a military policeman in the D.C. Army National Guard. He is also a veteran of the Gulf War.

Testifying also is Mr. Doug Vollmer, Associate Executive Director of Government Relations for PVA. Mr. Vollmer is involved in a variety of issues concerning PVA's members, such as the veterans and disability rights, for 26 years for the PVA.

We also have Tim Feeser. He is a principal with Reden & Anders, with a background in actuarial consulting services in the management of health care for 18 years. He has previously worked extensively with forecasting health care demand and has provided assistance to hospitals regarding service demand planning.

So I want all of you to know what we have attempted to do here today is not only examine what you do in the private sector, what you have done within DOD, the transitions you are doing to DOD through a new model and what your model has done. Even though it has pressed the horizons, you have been very fortunate for the last 4, 5 years. This year, regarding the challenges and workaround solutions for which we will be attentive and provide our oversight, please help us in a bipartisan fashion as we move forward into 2006.

We will receive our input from the veterans service organizations. We are all advocates. That is what I like about this. Whether on the Committee or in the VA or DOD or the VSOs, no one has the corner on the advocacy for our veterans.

Thank you very much. Panel one is excused.

Mr. Boozman. [presiding.] We appreciate you all coming.

Our second panel consists of Mr. Steve Robertson, who serves as Director of the National Legislative Commission of the American Legion. Prior to joining the American Legion, Mr. Robertson served as the Disabled Veterans Program Specialist For Job Service, North Dakota, and is a military policeman in the D.C. Army National Guard. He also served in the U.S. Air force for 12 years. My father was retired Air Force.

Mr. Douglas Vollmer is the Associate Executive Director, Government Relations, for Paralyzed Veterans of America. Mr. Vollmer has been involved in a variety of issues concerning PVA's members, such as veterans and disability rights for 26 years at PVA.

Mr. Tim Feeser is a principal with Reden & Anders, Limited, with a background of actuarial consulting services in the managed health care arena for 18 years. He has previously worked extensively with forecasting health care demand and has provided assistance to hospi-

tals regarding service demand planning.

Your prepared statements will be entered into the record.

STATEMENTS OF STEVE ROBERTSON, DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION; DOUGLAS K. VOLLMER, ASSOCIATE EXECUTIVE DIRECTOR, GOVERNMENT RELATIONS, PARALYZED VETERANS OF AMERICA; AND TIM FEESER, FSA, PRINCIPAL, REDEN & ANDERS, LTD.

Mr. Boozman. I now recognize Mr. Steve Robertson.

STATEMENT OF STEVE ROBERTSON

Mr. Robertson. Thank you, Mr. Chairman; and I do agree this is a very important hearing.

The American Legion continues to advocate for adequate funding levels to ensure America's veterans receive the health care and benefits they have earned through their honorable military service.

The basic difference between the American Legion's VA budget recommendation and that of the President's budget request and the Congress' budget is that the American Legion's budget is demand-driven, whereas yours are often budget-driven. The American Legion's recommendations are probably more consistent with what the VA sends to OMB before the initial pass-back.

Mr. Chairman, of all of the budgeting models and methodologies available, Congress' budget process is probably the least effective to provide proper funding for the VA. The VA's Office of Assistant Secretary for Management and the folks who were here earlier are well staffed and are very competent professionals. However, the Congress and the American taxpayers are not getting their money's worth. The true budgetary needs of the VA are submitted to the OMB.

Clearly, if Congress and the American people were allowed to see the initial product, rather than the watered-down version, everyone involved in the budget process could work towards a solid product -- supported by the President, supported by Congress and supported by the American people. Nobody wants to shortchange America's veterans and their families. Nobody.

The American Legion does not advocate simply throwing money at a problem without accountability. However, we do believe that VA needs the fiscal resources to operate the very best system possible. Maintaining a strong national defense is a top national priority, while VA is the end-product of winning wars and maintaining peace.

Clearly, there are tremendous differences between the budgeting models and methodologies between VA and DOD medical care. In the VA health care delivery system, not all veterans have equal ac-

cess to the quality of care that they want to receive, even if they are willing to pay for it. Currently, new Priority Group 8 veterans -- those most likely to have resources and third-party insurance coverage -- are denied enrollment regardless of their honorable military service in combat or peacetime.

Within the Department of Defense, all eligible beneficiaries are welcomed to enroll and have equal access to timely health care within their assigned regions.

The American Legion's budget methodology basically relies on internal and external factors. Some of the internal factors are: A System Worth Saving, a publication we put out each year; the CARES Task Force, another internal organization -- program of our organization; a formal network of service-officers that actually work in and around VA medical facilities; a network of homeless veterans program advocates and providers; information we receive from other advocacy groups; and, of course, informal government resources.

External factors include such things as the Presidential task force that we just completed that was to look into ways to improve health care delivery for our Nation's veterans. The President's budget request is very helpful. The budget resolution gives us a look ahead of where you are planning on going. Of course, the annual VA budget.

The American Legion's health care modeling. We were deeply concerned in the '80s with the fact that few veterans had access to the system. Primarily service-connected disabled veterans, economically indigent, and CHAMPVA eligibles were the ones that had access, but even that access was very, very complicated. Military beneficiaries were also having trouble with CHAMPUS, having trouble with timely access and soaring costs. The American Legion believed there was a better way to meet the health care needs of American veterans and their families. After much deliberation, the American Legion offered to Congress a new health care model that was extremely visionary for the VA health care delivery; and we called it the GI Bill of Health.

Some of the key factors of that talked about mandatory versus discretionary funding, Medicare reimbursement for the VA, third-party reimbursements not being counted as an offset to the discretionary account, the enrollment process, the defined benefits package so there was no doubt as to what kind of health care you were entitled to, timely access standards, availability of services, and also how the money was distributed within a VSIN.

Mr. Chairman, VA, Congress and the American Legion all share the same goal. That is, meeting the needs of America's veterans. Working together, we can achieve that goal. It is all about national priorities.

Mr. Chairman, that concludes my testimony.

Mr. Boozman. Thank you, Mr. Robertson.

[The statement of Steve Robertson appears on p. 75]

Mr. Boozman. Mr. Vollmer.

STATEMENT OF DOUGLAS K. VOLLMER

Mr. Vollmer. Thank you, Mr. Chairman; and I want to thank the members of the Committee on behalf of Paralyzed Veterans of America. We appreciate this opportunity to present our views and experiences on the methodology used in formulating the annual recommendations contained in the Independent Budget. In general, I will keep my remarks centered on the major budget accounts supporting the provision of VA medical care.

The first Independent Budget was published 19 years ago. The former VA Chief Medical Director and Surgeon General of the Navy, Retired Vice Admiral Donald Custis, suggested that the four veterans' service organizations form a unique partnership to develop and publish yearly VA budget views and estimates. The resulting Independent Budget would be used to demonstrate the actual financial needs of VA health care and other programs in the face of administration budget requests and congressional appropriations that were far too often influenced more by political considerations and the changing pressures of Federal budget policy than by objective budget modeling.

The Independent Budget presents a full budget model. It is the same model that VA uses at the beginning of its annual budget process. The VA and administration generally abandon this process at that point. At this time the VA budget then leaves the arena of pure budget modeling and enters the long road to OMB and the congressional budget and appropriations process, as being shaped by "what the freight will bear" in the competition for funding with all other domestic discretionary programs.

The IB does not take this course. It simply takes the amount of the current year appropriations and adds to each account assumptions regarding inflation and salary increases to arrive at a current services estimate for the upcoming year. The current services baseline is a commonly understood concept in Congress. In fact, the Congressional Budget Office is mandated by law to treat discretionary funding in what is essentially a current services model.

A current services estimate provides a baseline that presents a theoretical value of what it would cost to provide the same level of services in the following year as was provided in the current year. From that point, the Independent Budget presents an estimate as to the cost of individual recommendations found within the document, such as increased FTE, increased patient loads and changes to current policies.

I am attaching a white paper prepared and submitted to the Com-

mittee at the request of the Chairman earlier this year, and I request that it be placed in the record. This paper provides additional technical detail of how we assess the impact of annual wage and salary increases as well as formulas for estimating the effect of general inflation and other specialized indices on the VA budget accounts.

[Information provided appears on p. 89]

In closing, PVA, on behalf of the other Independent Budget veterans' services organizations, believes we can present and defend the full funding methodology that provides our annual recommendations. By contrast, any similar medical model that VA itself might put forward in initial recommendations for the following fiscal year becomes muddied in the actual ensuing budget and appropriations processes that follow. Overall budget increase requests are artificially skewed, claiming so-called increases that are only unrealistic management efficiencies. Budgets are inflated by equally unachievable third-party collections.

In terms of real requests for real additional appropriations, most administrations submit budgets on the cheap. They use no real medical model and leave it to the Congress to try to make the fix. The end result has no reality to the actual need, cost and demand of health care services. And from year to year, with the uncertainty of the budget and appropriations process, VA managers and the veterans they serve have little assurance that full support for their programs will be there when they need that support.

The Independent Budget VSOs can only come to the realization that the current budget system is flawed, unscientific and does not meet the true needs of the veteran population. For this reason, we endorse a new approach that will apply a realistic medical model to a guaranteed funding base that will support veterans' health care services to the extent that veterans need them and when veterans need them. Such a system is good public policy and good medicine.

This concludes my testimony, and I will be happy to answer any questions you may have.

Mr. Boozman. Thank you, sir.

[The statement of Douglas K. Vollmer appears on p. 84]

Mr. Boozman. Mr. Feeser.

STATEMENT OF TIMOTHY J. FEESER

Mr. Feeser. Thank you, Mr. Chairman and distinguished members of the Committee on Veterans' Affairs. I thank you for the opportunity to testify before you on the private sector approach to health care expense forecasting.

I am Tim Feeser, a principal with Reden & Anders. We are a national actuarial, clinical and management consulting firm that specializes in financial and business support decisions for the health care industry. In discussing our approach to the health care expense forecasting process, I would like to summarize how historical health care claims experience is used, how health care expense trend assumptions are developed and their application to historical experience to produce a forecasted health care expense budget. I will conclude with comments regarding the emerging practices seen as improvements to the health care expense forecasting process.

First, I will address the use of historical experience.

We would like to collect as much historical experience as we possibly can for an existing block of business as referred to in the industry. We would like to go back at least a minimum of 2 years, more if the data has been collected.

We then need to make adjustment to that information for estimated unpaid claims. That involves performing a lag analysis, which is used to complete that recent year's worth of experience, since at the time of performing your projections the total payments have not been made for all services delivered in that last calendar year of experience to be projected.

That is an important point in that, if you do not complete that experience, your base period will be understated; therefore, your future forecast would be understated, assuming your trends were correct.

After performing the lag analysis and completing your experience, you want to summarize that experience into meaningful expense categories before performing your projections. Typically within the industry we see groupings such as hospital inpatient care, with inpatient setting defined by type of stay, be that a medical stay, surgical stay, deliveries and the like. For outpatient hospital care, patient categorizations in the facilities include emergency room services, surgeries, diagnostic tests and other services.

On the physician side, services are grouped based on definition of service, using the CPT codes as the definition of classification. Meaningful categorizations are sensitive to how benefits change over time and helps in the modeling process, for example, categorizing physician services by routine office visits, elective surgeries, allergy, immunizations and the like, which are high-volume services delivered to the patient population.

Prescription drugs are also summarized separately by brand name prescriptions and separately for generic prescriptions.

Finally, you want to track your historical experience and segment it into what is referred to as allowed claims versus net paid claims, the difference being what the member pays as their out-of-pocket costs, whether that is copayments, deductibles and co-insurance.

I will address trend assumptions. In developing trend assump-

tions, we want to develop them specific to the medical expense categories that we discussed. We want to break out trend components, utilization and unit price, often referred to as medical cost inflation.

As an example to illustrate how the private sector drills down into analyzing the cost component, I will focus on the inpatient setting. A large insurer has several contracts with various hospital facilities across the country. Those contracts are renegotiated in a staggered way over time such that a high-volume hospital could become due for renegotiation and the health plan may expect a spike in their unit price that year for the hospital due to the hospital having not renegotiated their contracts for several years.

At the onset of those negotiations, the plan tries to gauge how rapidly those inpatient costs may increase, which could be as much as 20 percent if the hospital has not updated the contract with the health plan for several years. Inflator clauses are built into those agreements that may last 2 to 3 years out at a much lower rate.

So this drill-down analysis involves getting to an aggregate unit price trend based on how the individual facilities contracts come due over time, which affects the ultimate trend assumption implied for the unit price on the hospital side. This approach is used on the outpatient, physician and prescription drug side as well in developing unit costs.

After your trend assumptions are developed, you apply them to your historical experience to arrive at a forecasted budget, whether you are a self-insured employer or a health plan, forecasting your total expenses that underlie your pricing.

Finally, in closing, some advanced recent practices that are being used to help improve the forecasting process include more drill-down analysis of the impact of past technologies and new emerging technologies, a look at brand prescriptions going off patent and the impact of lower-cost generic prescriptions and the impact on trends and increased utilization of lower-cost generics and, finally, the importance of new disease management vendors that are having a great impact on managing chronic disease cohorts within an insured population base.

That concludes my testimony on the private sector's approach to health care expense forecasting. I would be happy to take any questions.

[The statement of Timothy Feeser appears on p. 93]

MR. BOOZMAN. Mr. Vollmer, a lot has been made about the disparity between the VA budgeting process and the Independent Budget. Can you describe again the basic fundamental differences as to how you arrive at your information versus the VA?

MR. VOLLMER. I believe we start at the same place the VA does, and we use a lot of VA data. We look at current services, what was

appropriated for the given year. We look at what the projected salary or wage increases will be, the rates of inflation, medical inflation, and build those up to make a VA budget for the next year that will reflect the same level of services that are currently being provided. At that time, we look at any additional costs or recommendations we would then be recommending within the context of the Independent Budget.

The VA does that at the same time when they initially develop their budget. But when they go through the pass-back series and it moves away from modeling and gets into the realm of political policy, their budget begins to be muddied and is pressured by the requirements for other domestic programs, for administration priorities, for all kinds of things; and it loses the true clean nature, I think, that it had when the first numbers were put together. That is when certain policies or decisions might be made to reduce 7s or 8s.

We predicate the Independent Budget funding for all veterans that would come into the system and not restricting access to certain categories of veterans. I think that is where we depart, particularly at the time of the pass-back and it moves out of the VA and into the broader political arena.

MR. BOOZMAN. The VA uses Milliman to validate their process. Do you use an outside source to validate it?

MR. VOLLMER. In the original development of the Independent Budget some 19 years ago, we had outside sources that worked with us. We brought some of those sources in house. We have had consultants over time that tweak or fine-tune the mechanism we need; and, in fact, in some modeling at VA we work with the Milliman people on developing modeling, various spinal cord injury care, for example.

MR. BOOZMAN. Mr. Robertson, your modeling is a little bit different in that it is a demand-based model, can you reiterate as to why you feel that is more accurate?

MR. ROBERTSON. Ours is validated by patients being turned away from the system, patients being denied timely access, facilities that are in need of repair, backlogs of inventory and equipment, robbing Peter to pay Paul accounts to keep the system going, to where we had to shut the doors at the end of the year. That is a pretty good validation process, because it deals with the lives of veterans.

I mentioned our program, that we have a system. We started this 3 years ago, where our national commander is visiting facilities -- our national commander right now is in Denver visiting the VA facilities in that area -- to compile a report.

A lot of the information we get comes back from VA employees. We sent questionnaires to all the facilities. We got back 125 out of the 163 we distributed. And this is all done with the help of the VA. In fact, we focused strictly on budget issues, and we sent out a second questionnaire that was a more narrowed focus on the facilities.

So, clearly, we can have all kinds of models and they can work really well if they are done the way they are advertised. But once it gets into this bureaucratic process --

And we all understand budgets. My boss sends me a thing telling me to do a budget. I put down what I want; and he tells me, this is what you are going to get. Do we run short? Absolutely. Does he know we are going to run short? Absolutely. And we deal with it down the road.

When you are dealing with the lives of veterans and their family members, we shouldn't be playing that kind of game. When we are talking about a decision to give them the best prescriptions possible or find the cheapest deal we can get away with, that is not honoring the service of the men and women that are allowed to go to the VA facilities.

MR. BOOZMAN. You mentioned mandatory funding as a method to make things better, and certainly that is being discussed here. I guess one of the concerns I have is that if you look at the countries that have done that then it seems inevitably it leads to the rationing of care. In other words, you wait a long time to get your hip replacement or knee replacement and things like that. Can you comment on that?

MR. ROBERTSON. There was one comment about setting up a system where all veterans would have access to the system.

First of all, if you look at every other health care system that is out there, whether it is DOD, Medicare or whatever, their enrollment participation of the number of people that are eligible versus the number of people actually enrolled probably runs 85 to 90 percent. People that are entitled to those benefits are using those benefits in large numbers.

Out of the VA health care system, there are 24 million veterans. Seven million have enrolled. So there is a little self-governing in here that needs to be understood.

If you do a mandatory funding formula or the guaranteed full funding formula that the American Legion has talked about, that still complies with the laws on the books. In other words, 7s and 8s, if they are being treated for nonservice-connected conditions, they will reimburse the government. There is still the obligation of them helping to pay for their care, which will help drive down the formula because of how much is actually having to be spent on health care.

Secondly, the VA, if you look at the cost per patient, is probably the best deal in the entire health care industry; and I think that was verified during the Presidential task force when they would show the cost of care for VA versus Medicare and versus DOD.

I think it is something that needs to be looked at. I think there are veterans that we say, in title 38, the Secretary shall provide care for and without question they should be included in that mandatory

funding cycle. All other veterans that come into the system, we have no objections with them paying for their care.

The final point is the Medicare reimbursements. I guarantee you there is not a health care professional in this country -- and I guess I am including you, too -- that you have a Medicare patient and the government told you you couldn't bill them, I don't think you would think that is a very good idea. And that is what we have done with the VA system. Right now, the VA is subsidizing Medicare to the tune of $3 billion because we can't bill for treatment of nonservice-connected medical conditions.

So many of these Medicare-eligible veterans want to come to the VA for so many good reasons: quality doctors, a database that maintains all their records in one place, a prescription plan that is affordable. I mean, the fact that if you go to a doctor on the outside, you have to find someone who is accepting new Medicare patients. If he sends you to a specialist, you have to go find a specialist that is accepting new Medicare patients. It is a hassle.

The VA system, because of its reputation of the quality of care, because of its accessibility, is a natural magnet for a lot of these folks. Why can't we take advantage of that? Why can't Medicare reimburse VA for the services it is rendering, because that is part of the discretionary budget?

Finally, counting the third-party collections as an offset, you have already talked about how bad the collection process is. That is a major part of the problem. When you offset the discretionary account, you are already putting everybody in the hole. When every distribution is made and the goals are given out to every medical facility, they are unachievable, and everybody knows it. So the VA directors are already working at a disadvantage.

And places where the collections are very good, what is their reward? They get a higher goal the next year. Places that do miserable, what is their reward? They get a higher goal. So there are a lot of problems that need to be fixed.

Our funding model, it may not be the most scientific in the world, but it is the most realistic in the world because we base it upon the services that are actually getting to GI Joe and Jane.

MR. BOOZMAN. Mr. Michaud.

MR. MICHAUD. The first question goes to Mr. Feeser. What would you do that would be dramatically different from what Milliman is currently doing in their modeling effort, if anything?

MR. FEESER. It would be difficult to really answer the question accurately without knowing a lot about the VA program in the level of detail that I need to know to comment on differences on modeling techniques.

But from what I gathered in the conversation this morning, it appears as such that the mechanics seem fairly standard of the indus-

try in the approach taken, looking at historical utilization experience, and unit pricing assumptions and attempting to complete that experience for lag and then projecting that out to a future point in time.

I believe the point was also made that the model's forecast is as accurate as it can be for the first year of the budget you are projecting. The ensuing years after that, the projections would be very soft. As more information emerges that was unknown and gets accounted for in a second forcast, that forcast should be improved.

It is hard for me to specifically point to differences in what we do versus what has been done.

Mr. Michaud. My next question is both for Mr. Robertson and Mr. Vollmer. You both talked a lot of your members, and I guess I am looking at the outcome. And we heard the Assistant Secretary of the VA talk this morning about taking care of the veterans needs. Are you hearing that from your veterans as far as demand for health care? Is it being met?

Mr. Vollmer. Steve, if I may.

Mr. Robertson. Go ahead.

Mr. Vollmer. I would say that with the veterans returning from Iraq and Afghanistan getting into the system, as Dr. Perlin has said, the things that concern us is that the older veterans are getting pushed out the back end as they are moving in the front end. They have been put on the curb. But their appointments are being delayed. Time is being stretched out. I think we will see more of that as we talk to individual hospital directors and health care providers around the country.

The shortfall Dr. Perlin acknowledged for this year where they are borrowing from all types of accounts to keep the ship afloat, they realize come October first, if not sooner, that when they are dealing with the 2006 appropriated level they are going to be in even more trouble.

We talk about the problems that transpire with just the budget that is sent from down the street up to here for the Congress to wrestle with. Well, that included a 2.3 percent salary increase and just this week the Appropriations Committee passed a 3.1 percent increase for pay raises for employees. The VA has over 180,000 employees. That money is going to have to be eaten by managers in every station around the country, and the only way that gets eaten is by either having fewer employees or treating fewer veterans.

So while the statement is made that we aren't turning veterans away by extending either waiting times or services available -- and I got a call other day, you know. There are some beds that are closed because they haven't been able to recruit staff and that may be a manager's way of just extending his budget as far as possible.

Mr. Robertson. As far as how is it coming out at the other end of the pipeline, every veteran that I know, most of the ones that I know

who use the VA system rave about the quality of care. They are happy about going to VA and it is usually their health care provider of choice. The problem is the ones that can't get in or the ones that have delayed access and they have to go some place else because their medical condition needs more timely attention.

But it is things like this, the letter that came out of the VA medical facility in Alexandria where they are acknowledging to the new 7s that maybe want to enroll in the system that they have suspended -- the suspension of appointments is temporary, depending on the availability of resources. It will affect all VA medical facilities within the south central VA hospital health care network. This came from the hospital director to folks, telling them you can enroll but we are not going to be making any appointments for you. That is the most classic example.

The most shocking thing I think I heard today, I think, is the comments made about, well, we plussed up the budget by about a billion dollars. If you look at that account, most of that billion dollars came from taking money away from VA administration and VA facilities, the exact same thing Dr. Perlin was talking about, shifting money from one pot to the other.

So, yes, in the press release we have got a one billion dollar increase, but in reality we just rearranged the deck chairs. And I think that that is -- when you take the money away from those accounts, that is where the doctor gets his money to be able to stretch out the budget to the end of the year, and you have already done that for him.

MR. MICHAUD. Mr. Chairman, I would ask that that letter be submitted for the record.

THE CHAIRMAN. Without objection.

[The information appears on p. 111]

MR. MICHAUD. Did you have a follow-up.

MR. VOLLMER. Yes, sir, we sat here and heard about all this modeling and how surprised people were that there is a billion dollar plus shortfall and there may be shortfalls in the future. I would just like to mention 2 years ago then Under Secretary of Health, Dr. Robert Roswell, testifying before this Committee, when questioned about mandatory funding just kind of on the back of an envelope sketched out how he viewed, without a lot of sophisticated modeling, where prices would go and just in a sentence I would quote Dr. Roswell. So a 7 percent increase associated with the enrollment in our highest priority groups coupled with another 2 to 3 percent of increased utilization costs coupled with a conservative estimate of health care inflation rates of 4.5 to 5 percent yield a 13 or 14 percent per year increase in the money available to take care of just our core population. I think that, you know, using 13 to 14 percent every year we shouldn't be off by a billion dollars.

MR. MICHAUD. I notice there is a rep still here from Milliman. I am just wondering what was the total dollar figure as far as using their funding model, and what was actually needed?

MR. ROBERTSON. I don't think that information was given out to date. I didn't hear it. I would have loved to have heard it.

MR. MICHAUD. Mr. Chairman, actually since we are talking about doing models, and I know since someone here is still from Milliman, I was wondering what the funding model that was presented, what the dollar figure was. And she is here. And I was wondering what that dollar figure was, if she could let me know.

MR. BOOZMAN. Sure.

MS. PATTERSON. I don't have the numbers with me. I apologize. I didn't realize I was coming today to testify about values. We provide many different models.

MR. MICHAUD. Would you provide that model to the Committee, the dollar? Using your modeling method, you came up with a number and I would like to know what that number is. If you can provide it to the Committee.

MS. PATTERSON. It is -- I apologize. It is not mine. I develop it for VHA.

MR. BOOZMAN. Why don't you come up and say that in the microphone.

MS. PATTERSON. The model is produced for VHA by my firm and, given their permission, we will provide whatever it is that you would like to see.

MR. MICHAUD. Is there still someone in here from the Department?

MR. BOOZMAN. Come on up. I know it is a hassle.

MR. KLEIN. When the budget is presented, it passes through what one would assume is a current services budget, but it includes the assumptions of other policies that change that dollar level. For instance, in the 2006 budget it had the 250 dollar enrollment fee, which reduces the overall dollar estimate for the medical care appropriation. It also contained the increase in the pharmacy copay. So you could almost back into the number that the actuary model would provide. It also included -- in that budget are efficiencies that --

MR. MICHAUD. If I might interrupt. I don't want to back into anything or do any assumptions. I would like to get to the point where we are talking about modeling and how accurate it is, the Independent Budget, you know their modeling. And I would like to know what that model recommended that was adequate to take care of the VA. And I think if we get that number of what that model is and what it is going to take to deal with the VA, I think we have a better idea on the assumptions, you know, where the model might be going wrong versus what actually was submitted because what was submitted does not take into account -- will take into account but it is driven by

dollars. It is not driven by a natural model. If we are going to figure out whether that model is accurate we have to figure out what that number is in that model, not what we are dealing with in terms of the actual budget, and that is why I would like to know under that modeling what is that number so we can figure out whether it was accurate or not and where we have to adjust the model to make sure we do get an accurate account.

MR. KLEIN. I think we can provide that for the record.

MR. MICHAUD. Thank you very much, appreciate it.

[The information follows: Although I must adhere to the embargoed nature of the information and discussions that go into building a President's budget, it is important to address your request. The model is one of many inputs to building the budget. Taken out of context, the model projections do not represent the entire health care requirements supported by the budget as it excludes non-modeled programs such as readjustment counseling, dental care, long-term care and CHAMVA. In addition, since the model was used to estimate teh impact of the user fee proposals, the model's total expenditure projection would have been reduced by these budgeted policies.]

MR. ROBERTSON. I do have one concern with that model because as it was pointed out during the testimony there are several different models that are used in conjunction with that. And I think about CARES that we just completed. The long-term care in the mental health portion of CARES was not included as part of the evaluation of CARES because they said the modeling for that was not what they really thought it should be.

So I mean we have got a situation now where we have veterans coming back where they are going to be in need of long-term care and yet we don't even know if we have the modeling to adequately provide for the treatment of long-term health or mental health problems of those returning veterans.

MR. MICHAUD. That is a good point and I guess if we are going to look at modeling and trying to figure out what the actual dollar amount is going to be needed to take care of our veterans, I think we have to be aboveboard and look at what we currently have and look at the whole system. And as you heard a statement made earlier, at the earlier panel, that former Secretary Principi was aboveboard and honest with the Committee when he said he needed another $1.2 billion to adequately meet the needs of our veterans.

I appreciate someone who is willing to be honest with the Committee, and I think it is important that we have that not because we are going to try to point blame or anything. It is just that as elected officials, if we are going to do our job and do a job that is effective, we have got to have accurate information. And I am not looking at pointing blames. I want to make sure we take care of our veterans.

And that is why I think it is important to know, number one, what the VA actually requested versus what we are dealing with but also, number two, what the modeling was actually given to VA just so we can compare the three. And I think it is very important for us to have that information.

Mr. Robertson. Well, piggybacking on the comment the gentleman just made, when the initiatives were listed in the budget for third party -- I mean for increased copayments for prescriptions and the enrollment fee, the modeling said that there would probably be 1.1 million veterans that would probably disenroll from the system rather than pay those increased rates. So it does have an impact on what is going to be the reaction of the veterans population. Are we really in the business of driving people out of the system? And I think the answer is no.

Mr. Michaud. And I agree.

Mr. Boozman. I want to thank our panel. Do you have any other things? You are free to go. Okay, good.

Again I want to thank both panels for being here today. I think this was a very, very good hearing. Certainly, we all share frustration, I think, of trying to get this right. As Mr. Michaud said, we need accurate information to be able to make a determination of where we go with this. I was in Landstuhl, Germany 3 or 4 weeks ago and visited with a young guy -- we were there at 2 o'clock in the afternoon. This individual had run over a explosive device at 4 o'clock the previous morning Iraqi time. Cleaned him up and flown him there -- and literally was just coming out of surgery. But he wanted to tell us his story as to what had happened. He lost both legs below his waist and he wanted to know two things. He wanted to know about his wife. He hadn't been married very long, was she going to come, and they reassured him that yes, she would be reunited with him the next day. They were going to fly him to Walter Reed or Bethesda and that was taken care of. And the last thing he said to us, he said I saw it happen to my friends and my buddies. I saw it happen to my other guys in my unit. I never thought it would happen to me. And then he said, do you think I will ever get to walk again? And so we reassured him that was going to be the case.

So that is why I am on this Committee. Mr. Michaud and the rest of us, we do want to get this right.

The other problem is that tomorrow I am going to a funeral of my favorite uncle, he is a World War II guy and he has been very ill for the last 6 months and died as a result of congestive heart failure leading to needing massive, really significant surgery and just didn't come out of that. His medical bills in the last 6 months have exceeded all of his medical bills up to now. So there really are things like that, that are going on and make it so difficult.

We are running into the same problem with health care, not only

with the VA system, which is a wonderful system right now, but we are running into the same thing with Medicaid. We are running into it with private insurance. Health care now is very difficult to model by any sector that is doing it, whether it is the insurance company, whether it is the VA or whatever. So it is not something that I think there is any blame. I appreciate the Chairman, I appreciate the Ranking Member, for calling this meeting and this hearing. This is something that we do have together to get our arms around and I think there is a commitment to do that.

MR. ROBERTSON. May I make one comment in reference to the young man that you visited in the medical facility? You know we are going to take care of him, and we are going to take care of his family. But we also need to take care of the guys that rescued him off the battlefield, the ones who that flew him to the hospital and the ones that are going to treat him until he is discharged from the military. All of them should have access to the system, not just him.

MR. BOOZMAN. I understand and look, I said my wife's uncle, he was a World War II guy, and we have taken care of him. So I agree with you totally. And you can see when you go over to Iraq and you see those young guys and then you see our older vets, and can just see in the faces of both. They are just the same folks. I agree with you totally, so again that is our commitment, and I think today was a good step in that direction. So thank you very much.

[Whereupon, at 12:46 p.m., the Committee was adjourned.]

APPENDIX

STATEMENT OF
THE HONORABLE JONATHAN PERLIN, MD, PhD, MSHA, FACP
UNDER SECRETARY FOR HEALTH
VETERANS HEALTH ADMINISTRATION
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENATIVES

JUNE 23, 2005
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Mr. Chairman and Members of the Committee: I am pleased to be here this morning to discuss the Department of Veterans Affairs' (VA's) actuarial health care demand model. Accompanying me this morning are Rita Reed, VA's Deputy Assistant Secretary for Budget, Jimmy Norris, VHA's Chief Financial Officer, and Art Klein, Director for VHA's Policy and Planning. Mr. Chairman, I would like to submit a copy of my testimony for the record.

Background

Mr. Chairman, the Veterans' Health Care Eligibility Reform Act of 1996 established a uniform package of health care services for enrollees. The legislation also established a priority-based enrollment system and required the VA Secretary to annually assess veteran demand for VA health care to determine whether resources are available to provide timely, quality care to all enrollees.
Eligibility reform contributed to the transformation of the Veterans Health Administration (VHA) from a health care system that provided episodic, inpatient care to a health care system that provides a full range of comprehensive health care services to enrollees. The focus on health promotion, disease prevention and chronic disease management has resulted in more effective and more efficient health care. As a result, the range of health care services utilized by VHA patients began to mirror that of other large health care plans. Therefore, VHA decided to follow private sector practice and use a health care actuary to predict future demand for VA health

care services. Mr. Chairman, transforming from a hospital system to a health care system has facilitated VA's ability to take a leadership position in health care quality in the United States. A recent Washington Monthly article stated the Veterans Health Administration gives the "best care anywhere." Additionally, the results of a recent study conducted by the independent RAND Corporation revealed that based on 348 measures of performance, VA provides systematically better care in disease prevention and treatment. We believe our modeling and forecasting have seen dramatic improvements as well.

In the past, VHA budgets (and most Federal budgets) were based on historical expenditures that were adjusted for inflation and then increased based on proposed new initiatives. However, rather than an arbitrary increase over prior budgets, with the implementation of eligibility reform and the shift to ambulatory care, VHA needed to more rationally budget for veteran requirements in a transformed health care system. It also needed to be able to continually adjust its budgetary projections for effects of shifting trends in the veteran population, increasing demand for services, and the escalating cost of health care, e.g., pharmaceuticals.

As a result, VA engaged Milliman, Inc., to produce actuarial projections of veteran enrollment, health care service utilization, and expenditures. Milliman consults to health insurers and as such, is the largest and most respected actuarial firm in the country in the area of providing actuarial health care modeling. We appreciate the Committee issuing a separate invitation to testify to Kathi Patterson, a principal and consulting actuary with Milliman and the lead actuary working with VHA.

VHA Enrollee Health Care Demand Model

The VHA Enrollee Health Care Demand Model (model) develops estimates of future veteran enrollment, enrollees' expected utilization for 55 health care services, and the costs associated with that utilization. These projections are available by fiscal year, enrollment priority, age, VISN, market, and facility and are provided for a 20-year period.

The model provides risk-adjustment and reflects enrollees' morbidity, mortality, and their changing health care needs as they age. Because many enrollees have other health care options, the model reflects how much care enrollees receive from the VA health care system versus other health care providers. This is known as VA reliance. Enrollee reliance on VA is assessed using VA and Medicare data and a survey of VA enrollees. The VA/Medicare data match provides VA with enrollees' actual use of VA and Medicare services and the survey provides detailed responses from enrollees regarding

any private health insurance and their use of VA and non-VA health care.

The model projects future utilization of numerous health care services based on private sector utilization benchmarks that are adjusted for the unique demographic and health characteristics of the veteran population and the VA health care system. The actuarial data on which the benchmarks are based represent the health care utilization of millions of Americans and include data from both commercial plans and Medicare, and are used extensively by other health plans to project future service utilization and cost.

The model produces projections for future years using health care utilization, cost, and intensity trends. These trends reflect the historical experience and expected changes in the entire health care industry and are adjusted to reflect the unique nature of the VA health care system. These trends account for changes in unit costs of supplies and services, wages, medical care practice patterns, regulatory changes, and medical technology.

Each year, the model is updated with the latest data on enrollment, health care service utilization, and service costs. The methodology and assumptions used in the model are also reviewed to ensure that the model is projecting veteran demand as accurately as possible. VHA and Milliman develop annual plans to improve the data inputs to the model and the modeling methodology. Notably, Mr. Chairman, perhaps going to a focus of the Committee today, on average for the past three years, patient projections have been within -0.6 percent of actual patients and enrollee projections have been within +1.9 percent of actual enrollees.

As required by eligibility reform legislation, VA annually reviews the actuarial projections and determines whether or not resources are available to meet the expected demand for VA health care and develops policies accordingly. For example, the model's projection of continued significant growth in enrollment in Priority 8 formed the basis of VA's decision to suspend Priority 8 enrollment in January of 2003, to ensure that resources were available to provide timely, quality health care to enrolled veterans.

Over the past six years, VHA has integrated the model projections into our financial and management processes. The VA health care budget is now formulated based on the model projections, as are the impact of most policies proposed in the budget. The projections have been used throughout the CARES process to inform VHA's capital planning efforts and to support the development of VISN and program strategic plans.

Some services VA provides are not modeled by Milliman. These include readjustment counseling, dental services, the foreign medical program, CHAMPVA, spina bifida, and non-veteran medical care. Demand estimates and budgets for these programs are developed by

their respective program managers.

Enrollee demand for long-term care services is modeled by VHA. The VHA long-term care model uses utilization rates from nationally recognized surveys adjusted for the unique characteristics of the enrollee population and known reliance factors to account for distance (access to VA facilities), multiple eligibilities, and case management to project demand for both nursing home care and community-based care.

The development of the actuarial model has been an evolutionary process, starting with the first model which provided single-year projections that were used only for the Secretary's annual enrollment decision on resource availability and enrollment levels. Enhancements include more detailed and robust adjustments for enrollee reliance, morbidity, and mortality, adding new data sources, and expanding the number of services modeled. Future planned improvements include access to data on enrollee's use of Medicaid, Tricare, and military treatment facilities, the integration of the VHA long-term-care model into the actuarial model, and modeling additional services such as dental care.

Conclusion

Mr. Chairman, in closing, I believe that the VHA Enrollee Health Care Demand Model is a valuable budgeting and planning tool for projecting VA health care utilization to ensure that VA can provide safe, effective, timely and efficient care. We combine VA's substantial experience with a contractor with unrivalled expertise in health care modeling to achieve the best actuarial projections possible.

This completes my statement. I will be happy to respond to questions from the Committee.

OVERVIEW STATEMENT BY

THE HONORABLE JOHN L. KOKULIS

DEPUTY ASSISTANT SECRETARY OF DEFENSE

FOR HEALTH BUDGETS AND FINANCIAL POLICY

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

MODELING AND BUDGETING FOR HEALTH CARE

IN THE DEPARTMENT OF DEFENSE

JUNE 23, 2005

NOT FOR PUBLIC RELEASE UNTIL
10:00 AM ON JUNE 23, 2005

Mr. Chairman and distinguished members of this committee, I want to thank you for the opportunity to discuss modeling and budgeting for health care costs in the Military Health System.

The Department of Defense (DoD) offers the TRICARE benefit to approximately nine million eligible beneficiaries. 19% of this population is made up of Uniformed Services personnel (Army, Navy, Air Force, Marine Corps, Coast Guard, Public Health Service and National Oceanic and Atmospheric Administration); their family members make up another 27%. Retirees, their family members and survivors account for 54% of our beneficiaries.

Approximately 20% of our beneficiaries are entitled to Medicare. DoD's share of their health care costs are paid from the DoD Medicare Eligible Retiree Health Care Fund, an accrual type fund established by Congress that began operations in Fiscal Year 2003.

For the rest of our beneficiaries, we must estimate and budget for the cost of their care as well as for the myriad of military unique readiness health care activities performed by the medical services of the Army, Navy and Air Force. We have three distinct missions in the Military Health System (MHS): Deploying a healthy and fit force, which involves force health protection activities such as the development and administration of vaccines and improving, medical surveillance, deployment health appraisals, and other health promotion activities (smoking cessation, etc.) to maintain the fitness of our war fighters; deploying a ready medical force capable of combat health support, which involves the movement into the theater of operations of field and fleet medical units such as combat support hospitals and aeromedical evacuation assets; and managing beneficiary care through the administration of the TRICARE benefit.

TRICARE, the Military Health Plan

TRICARE offers our beneficiaries a variety of options for obtaining health care coverage. TRICARE Prime is a health maintenance organization type option that requires enrollment. active duty personnel are required to use military treatment facilities (MTF) unless assigned to a remote location where there is no nearby MTF. In these cases, active duty personnel are enrolled in TRICARE Prime Remote and assigned a private sector primary care provider. Retirees, retiree family members and survivors have three options; TRICARE Prime, TRICARE Extra, and TRICARE Standard. Those age 65 and over may choose TRICARE for Life or TRICARE Plus. For TRICARE Prime, retirees and their family members under age 65 pay an annual enrollment fee ($230 for an individual and $460

for a family). Enrollees have the option of enrolling with a primary care manager at a local MTF if one is available or with a primary care manager in the private sector who is a part of the TRICARE network established under three regional Managed Care Support Contracts. Care in the TRICARE network requires nominal copays whereas care in the MTFs does not. TRICARE Extra is a preferred provider organization type benefit where private sector network providers agree to accept reduced fees in exchange for being included in the network. TRICARE Extra offers reduced beneficiary out of pocket costs compared to TRICARE Standard but has a more limited choice of providers. TRICARE Standard is a fee for service benefit that offers the greatest choice of providers but includes higher deductibles and cost shares than other TRICARE options. Outpatient pharmacy services are offered free at MTF pharmacies and with three tiered copays through the TRICARE Retail Pharmacy network, and the TRICARE Mail Order Pharmacy program. Copays are lowest for generic drugs included in the TRICARE formulary, higher for name brand drugs in the formulary, and highest for drugs not included in the uniform formulary.

We have now transitioned to new regional TRICARE Managed Care Support Contracts which include incentives for care referred by the contractor back to local MTFs, helping us to ensure maximum utilization of our in house care services.

The challenges we face as we prepare our annual budget requests include predicting how many of our eligible beneficiaries will use their TRICARE benefit, what option they will select, how often they will require care or prescriptions, what inflation rates will impact our procurement of services from the private sector, and the impact of recently enacted changes in benefits.

The expansion of benefits, such as those for Reservists and our senior retirees, contributes to the growing size of our budget. At Congress' direction, we implemented new TRICARE Reserve benefits that facilitate the individual medical readiness of members of the National Guard and Reserve, and contribute to the maintenance of an effective Reserve Component force. The National Guard and Reserve are doing an outstanding job and they deserve an outstanding benefit. We provide that to them. We have made permanent their early access to TRICARE upon notification of call-up, and their continued access to TRICARE for six months following active duty service for both individuals and their families. We have implemented the TRICARE Reserve Select (TRS) coverage for Reserve Component personnel and their families who meet the requirements established in law. TRS is a premium-based health care plan, at

very attractive rates, available to eligible members of the National Guard and Reserves who have been activated for a contingency operation, on or after September 11, 2001.

MHS Funding

We face tremendous challenges in funding a benefit design that does not always reward the efficient use of care. Further, we are increasingly out of step with the benefit design approaches and trends of the private sector. We must address these issues, engage in constructive dialogue, and do what is right for our current and our future generations. Our primary goal is to ensure the military has a high quality, yet affordable, health benefit program for the long term.

Defense Health Program (DHP) costs continue to rise due to increased utilization of the MHS. The Fiscal Year 2006 DHP funding request is $19.8 billion to finance the MHS mission. Our funding growth is the result of expanded benefits for our beneficiaries, to include the Reserve Components; increased health care costs in the private sector; increased utilization of health care services and pharmaceuticals; the inherent design of the current benefit structure (e.g., no copayments for active duty family members, no non-availability statements, decreased catastrophic caps, etc.); and the decision of eligible beneficiaries, principally our retirees, to drop private insurance coverage and rely upon TRICARE.

DoD has taken several actions to better manage resources. The MHS is implementing performance-based budgeting, focusing on the value of services delivered rather than using old cost reimbursement methods. We are introducing an integrated pharmacy benefits program that uses a standardized formulary that is clinically and fiscally sound. Quality management programs continue to ensure that care provided is clinically appropriate and within prescribed standards.

With the phased implementation of a new Prospective Payment budgeting approach, we are moving to performance-based budgeting for our MTFs. We intend to base MTF budgets on workload output such as hospital admissions and clinic visits, rather than on historical resource levels such as number of staff employed, supply costs, and other materials. We will pay a "competitive market price" for these outputs, providing financial incentives and rewards for efficient health care delivery. In addition to paying for heath care delivered, we are also developing methods to determine the cost to our MTFs of maintaining a medically ready force as well as a ready

medical force. Some of these costs are included in the costs of health care delivered, but others are above this amount. Once fully implemented, PPS should allow for better management and performance of all three of the MHS missions.

Our pharmacy budget has increased five-fold since Fiscal Year 2001 and now stands at $5.5 billion ($1.9 billion of this amount is not in our budget request as it is funded by the DoD Medicare Eligible Retiree Health Care Fund). The redesign of our pharmacy programs into a single, integrated program, beginning in June 2004, simplifies and allows us to more effectively manage this program. We are standardizing formulary management, achieving uniform access to all medications, enhancing portability, and involving beneficiaries in formulary decision-making. We will promote the use of more cost-effective products and points of service.

We strive continuously to improve the quality of care delivered throughout the MHS, employing sound management practices and metrics to ensure appropriateness of care through a variety of quality management programs. We monitor the health of our population using Healthy People 2010 goals as a benchmark, and we measure the quality of care provided using Joint Commission on Accreditation of Health care Organizations Oryx indicators.

Sharing Initiatives with DVA

We continue to explore new avenues of partnership with the Department of Veterans Affairs. Our Executive Council structure serves as the setting in which the Departments jointly set strategic priorities, monitor the implementation of those priorities and ensure that appropriate accountability is incorporated into all joint initiatives.

The Joint Executive Council developed a Joint Strategic Plan for FY2005 that includes goals and objectives for the year, as well as performance metrics in the following areas:

- Leadership Commitment and Accountability
- High Quality Health Care
- Seamless Coordination of Benefits
- Integrated Information Sharing
- Efficiency of Operations

- Joint Contingency/Readiness Capabilities

We have worked closely with the VA to develop and implement the demonstrations projects and the Joint Incentive Fund (JIF) projects requested by Congress. Seven demonstrations are now underway, twelve incentive fund projects are in varying stages of initiation and 56 new JIF proposals have been submitted for review.

We are especially pleased with our work with the Department of Veterans Affairs for the seamless, responsive and sensitive support to Soldiers, Sailors, Airmen and Marines as they return to duty or transition from active duty to veteran status. An important aspect of this transition is having the individual medical records available when a separated service member presents at a VA hospital for the first time. We made significant strides forward by transferring DoD electronic health information of service members who leave active duty to a central repository at the VA Austin Automation Center. Some examples of data transfer provided through this repository include: VA clinicians and claims adjudicators have access to DoD laboratory results, radiology results, outpatient pharmacy data, allergy information, discharge summaries, consult reports, admission, disposition and transfer information, elements of the standard ambulatory data records and demographic data. To date, we have transferred this electronic health information on more than 2.9 million separated service members to this repository, and the VA has accessed more than 1 million of those records. We believe that this collaborative effort with the VA has been going extremely well and together, the DoD and VA are improving services to our veterans.

Modeling and Budgeting for Health Care

The DHP consists of three appropriations: Operation and Maintenance (O&M), Procurement, and Research, Development, Test and Evaluation (RDT&E). O&M, which comprises approximately 97% of the DHP budget request, is available for obligation for one fiscal year and is used to pay for the majority of our day to day operations. In recognition of the volatility of health care expenditures and the changes that occur in our program each year, Congress has allowed up to 2% of the DHP O&M appropriation to be carried over from one fiscal year into the next, essentially making that portion of the appropriation available for obligation for two fiscal years. Approximately 80% of the DHP resources are dedicated to provision of medical and dental care in both the direct care system and the private sector; the balance funds military unique requirements and specific readiness missions. Procurement, which comprises approxi-

mately 2% of the DHP budget request, is available for obligation for three fiscal years and is used to pay for the acquisition of specific items or systems with a unit cost of $250,000 or more. RDT&E, which comprises less than 1% of the DHP appropriation, is available for obligation for two fiscal years and is used to pay for the development of new systems, such as basic and applied research, advanced technology development, demonstration and validation, engineering development, developmental and operational testing, and the evaluation of test results. We typically receive about $400 million above our DHP RDT&E request to fund Congressional interest items. All DHP appropriations are allocated in accordance with guidance provided by the Secretary of Defense and more detailed guidance provided by the Assistant Secretary of Defense (Health Affairs).

In addition, DoD also budgets for two more appropriations not included in the DHP. The Military Personnel Appropriation pays for military personnel assigned to MHS activities, such as hospitals and clinics, and the Military Construction appropriation pays for new construction or major modification of MTFs, medical research facilities, and other medical buildings.

The DHP O&M appropriation is divided into seven Budget Activity Groups (BAGs). Funding within each BAG is further separated into commodities and inflated at specified OMB inflation rates.

BAG 1 – In-House Care – Funds patient care and pharmacy services in Medical and Dental Treatment Facilities world wide. This BAG is further divided into three major categories: health care delivered in MTFs, dental care and pharmaceuticals.

This budget activity group comprises about 27% of the total O&M appropriation. Budgeting for health care in MTFs is currently undergoing a phased transition to the Prospective Payment System, the performance based budgeting process previously described. For the Fiscal Year 2006 DHP budget, 50% of this category will be funded through prospective payment and 50% based on historical resource levels such as number of staff employed, supply costs, contracts, and other categories adjusted for inflation using OMB inflation rates. We plan to base our Fiscal Year 2007 budget request on 75% implementation of Prospective Payment and move to full implementation in Fiscal Year 2008. The DHP-resourced medical services of the Military Departments (Army, Navy and Air Force; health care services for the Marines are provided by the Navy) develop detailed business plans to determine the amount and type of inpatient and outpatient workload that they will produce and be funded for by Prospective Payment during the budget year.

Budgeting for dental care currently is based on historical resource levels adjusted for inflation but we plan to develop and implement a prospective payment process for this category in the near future.

Pharmacy, as previously mentioned, has been an area of significant cost growth in recent years. For the In-House Care BAG, budgets are based on historical costs adjusted both for inflation and for actuarially derived trends in utilization; the development of new drugs has resulted in increased numbers of prescriptions for existing TRICARE users, and the previously mentioned effect of beneficiaries who were not using TRICARE but are now dropping their private insurance has also increased demand for pharmaceuticals.

BAG 2 – Private Sector Care – Funds patient care and pharmacy services purchased from private sector providers (Managed Care Support Contracts, Retail and Mail Order Pharmacy, Supplemental Care, Purchased Dental Care, the Uniformed Services Family Health Plan, and other requirements).

This budget activity group comprises about 53% of the total O&M appropriation. Private Sector Care requirements depend heavily on accurate estimates of workload produced by MTFs, as well as accurate actuarial forecasts of private sector health care cost growth, increased utilization of health care services by TRICARE users, and increased numbers of TRICARE beneficiaries who use TRICARE as their primary insurance. In addition, changes to the TRICARE benefit directed by Congressional action have a significant impact on the funding required in the budget.

We have developed a Private Sector Care Requirements Model that takes these factors (as well as many others) into account in forecasting budgetary requirements for this BAG.

BAG 3 – Consolidated Health Support – Funds entrance examining activities, occupational health, veterinary services, aeromedical evacuation, the Armed Forces Institute of Pathology and other military unique health activities.

This budget activity group comprises about 6% of the total O&M appropriation. The primary cost drivers are the volume of force health protection activities, aeromedical evacuation requirements, and volume of entrance examinations (recruits). Budgeted amounts are based on historical resource levels adjusted for inflation using OMB inflation rates, plus any new missions or initiatives directed by senior leaders (“programmatic” changes) or by Congress. For

example, the recently directed increases in Army and Marine end strength drive increased requirements for military service entrance examination activities.

BAG 4 – Information Management/Information Technology (IM/IT) – Funds both the Central and non-central, Service Medical IM/IT programs. The Central program funds system program management, system and infrastructure sustainment, annual software licensing and equipment lease costs. The non-central funds provide for unique military service and Tri-service systems, communications and computing infrastructure, information assurance, long haul/wide area communications, office automation, video-teleconferencing, and other technical activities.

This budget activity group comprises about 4% of the total O&M appropriation. The primary cost drivers are the phased fielding requirements of corporate information systems, life cycle replacement costs of these systems, and internally or externally directed security requirements.

BAG 5 – Management Activities – Funds the military department medical commands and the TRICARE Management Activity.

This budget activity group comprises about 1% of total O&M. We project requirements primarily based on the historic funding baseline adjusted for inflation at OMB rates.

BAG 6 – Education and Training – Funds the Health Professions Scholarship Program, the Uniformed Services University of the Health Sciences and other education and training programs.

This budget activity group comprises about 2% of total O&M. The primary cost drivers are the number and composition of our medical force structure (military and civilian) and the projected recruiting requirements for clinical professionals through the Health Professions Scholarship Program (HPSP), the Health Professions Loan Repayment Program (HPLRP), the Financial Assistance Program (FAP) and the Uniformed Services University of the Health Sciences (USUHS). The major areas of concern within this budget activity group are the escalating costs of tuition and the recruiting and retention rates of clinical personnel.

The military service medical departments have student output models that drive the requirements for in-house training requirements. This is based on personnel being promoted, separated or retiring. Additionally, we have an Intraservice Training Review

Organization (ITRO) that manages additional training requirements from the Services and determines the most efficient means to train them. Many medical courses have been consolidated and are structured to be used by all military services to achieve more cost effective use of available resources.

Total Student Allocations are determined by law with the Assistant Secretary of Defense (Health Affairs) determining the number of funded student allocations. Service force management offices determine requirements for student allocation by analyzing specialty outputs (retirement, separation) and inputs (direct accessions, military academies, the Reserve Officer Training Corps). These numbers are entered into a Force Management Tool to determine requirements for each specialty.

BAG 7 – Base Operations/Communications – Funds Facility Restoration, Modernization and Sustainment, Real Property Services, Communications, Environmental and Base Operations Support costs.

This budget activity group comprises about 6% of total O&M. While this BAG supports many facilities-related activities, it is worth noting how the specific process by which we fund the normal maintenance of our existing DHP infrastructure. We in the DHP are responsible for a large, diverse inventory of facilities with a replacement value of approximately $19 billion. To properly sustain this inventory, we use the Facilities Sustainment Model (FSM) that integrates:

- Real property inventories
- Unit cost factors for sustainment differentiated between facility types by using DoD\Facility Analysis Category (FAC) codes
- Business rules for assigning sub-organization and fund source responsibilities
- Forecasts of planned inventory changes, such as new construction and disposals

For each of the FAC codes, a unit cost factor for sustainment was developed based upon commercial cost benchmarks and tailored to the specific facility composition. The FSM itself combined the standardized inventory and unit cost factors with a host of busi-

ness rules to generate an objective, auditable facilities sustainment requirement in sufficient detail to be useful to all MHS users.

DHP Procurement Appropriation

Roughly half of DHP procurement funding supports the purchase of information systems, and half supports purchase of medical and dental equipment. Requirements are driven by lifecycle replacement, new technology advances, and construction of new or renovation of existing facilities.

DHP RDT&E Appropriation

The DHP RDT&E Appropriation represents less than 1% of the total DHP appropriation and has historically primarily supported information management and information technology development efforts. Beginning in Fiscal Year 2006, the DHP RDT&E appropriation will also fund medical research laboratories transferred from the line Navy; the Armed Forces Radiobiology Research Institute transferred from the Director, Defense Research and Engineering; and two new initiatives - the Epidemiologic Outbreak System, and the SuperVision program. The Epidemiologic Outbreak System will provide a bio-defense system for early threat warning, rapid threat identification, and focused treatment and outbreak containment. SuperVision, a human performance enhancement program, will maximize war-fighter effectiveness to operate under adverse conditions. We typically receive about $400 million above our request to fund Congressional interest medical research.

Military Personnel (MILPERS) appropriation

MILPERS costs are estimated by the military services using a “composite” or “programming” rate that takes many factors into account, such as authorized end strength, grade mix, promotion timing, separation/retention rates, pay raises, recruiting costs, travel and temporary duty costs, and contributions to the DoD Medicare Eligible Retiree Health Care Fund, among other factors.

Military Construction (MILCON) appropriation

The MILCON Appropriation provides for the design and construction of projects that allow us to replace or update our current facilities. Additionally, modernization work over the O&M Appropriation limit of $750,000 (or $1,500,000 if the project is strictly to alleviate health or safety deficiencies) is included in this account. As part of

the life cycle cost analysis of our medical facilities, we monitor the facilities' recapitalization rate. Recapitalization is a combination of restoration and modernization. Restoration returns performance to original levels or, alternatively, to the level defined by the normal degradation curve. Modernization, on the other hand, raises performance to a new level, beyond the original level. An example is the incorporation of force-protection enhancements into modernization projects at defense facilities. The modernized facilities will perform better, due to the addition of force-protection features, than they did originally.

Since recapitalization can include restoration and modernization, as well as replacement, we employ both MILCON and O&M to keep our facilities current with modern health care practices and market conditions. The cost of maintaining and upgrading facilities is a major component of the operations and capital budgets of medical facilities. The DoD target rate for recapitalization is equal to the estimated service life of facilities (50 years for medical facilities and 67 years on average for all DoD facilities). The ability to retain our critical medical infrastructure base in a safe, secure, fiscally and operationally efficient manner is a challenge. Even when optimally maintained, facilities eventually either physically wear out or become functionally obsolete. Appropriate investments are required to "reset" the life expectancy of our aging infrastructure.

Conclusion

We operate an incredibly complex and capable health care system--one that provides world class health care both at fixed facilities here in the United States and abroad and within the deployable units world wide that support the Global War on Terrorism. It is our enduring responsibility to ensure we maintain a healthcare system that delivers a fit and ready force on the battlefield, and also secures the well-being of families and other beneficiaries here at home. We face many challenges in meeting these missions in a cost effective manner without degrading the support we provide to current and retired members of our Nation's Uniformed Services and their families. We are exercising prudent management in our cost control efforts but increasing demand, added benefits and high inflation for health care services tend to obscure our efforts, particularly when we are estimating costs for services to which our beneficiaries are entitled by law within the limits of the rules of appropriations law.

We are exercising our strategic and business planning processes to ensure we effectively address readiness, capital needs, and chang-

ing infrastructure. We continue to pursue higher levels of system efficiency and clinical effectiveness and deploy information technologies and management systems that support greater performance, clarity and accountability. We are implementing critical new cost control initiatives such as prospective payment and improved Managed Care Support Contracts.

The military medical community has often been a powerful influence in building national relationships that foster freedom and liberty. Today, we also directly support our Service members who fight to help others secure their freedom. Our MHS is truly a precious national asset. The reason military medicine has succeeded and why it will continue to succeed goes beyond 'hard work' -- it goes to the will and character of the American people. We are confident that our mission -- caring for the Uniformed Service members who keep this Nation safe and secure, and to care for their families -- has no greater calling or cause.

Thank you.

Budgetary Inflation Rates Applied to the Defense Health Program

Budgetary Inflation Rates Applied to the Defense Health Program

FY05-06 Inflation Rates

Budget Activity Group	IHC	PSC	CHS	IM	MA	E&T	BOS
Travel of Persons	0.021	0.021	0.021	0.021	0.021	0.021	0.021
DFSC Fuel	0.097	0.097	0.097	0.097	0.097	0.097	0.097
Service Fund Fuel	0.097	0.097	0.097	0.097	0.097	0.097	0.097
Army Sup & Mat	0.025	0.025	0.025	0.025	0.025	0.025	0.025
Navy Sup & Mat	0.077	0.077	0.077	0.077	0.077	0.077	0.077
AF Sup & Mat	0.057	0.057	0.057	0.057	0.057	0.057	0.057
DLA Sup & Mat	0.012	0.012	0.012	0.012	0.012	0.012	0.012
GSA Sup & Mat	0.021	0.021	0.021	0.021	0.021	0.021	0.021
Local Proc Sup & Mat	0.021	0.021	0.021	0.021	0.021	0.021	0.021
Army Fund Equipt	0.025	0.025	0.025	0.025	0.025	0.025	0.025
Navy Fund Equipt	0.077	0.077	0.077	0.077	0.077	0.077	0.077
AF Fund Equipt	0.057	0.057	0.057	0.057	0.057	0.057	0.057
DLA Fund Equipt	0.012	0.012	0.012	0.012	0.012	0.012	0.012
GSA Fund Equipt	0.021	0.021	0.021	0.021	0.021	0.021	0.021
Army Depot Cmd Maint	0.007	0.007	0.007	0.007	0.007	0.007	0.007
Naval Surface War Ctr	0.027	0.027	0.027	0.027	0.027	0.027	0.027
Data Automat Ctr Navy	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Fleet Aux Ships Navy	0.114	0.114	0.114	0.114	0.114	0.114	0.114
Naval Rsch Lab	0.034	0.034	0.034	0.034	0.034	0.034	0.034
Naval Civil Engnr Ctr	0.016	0.016	0.016	0.016	0.016	0.016	0.016
Naval Pub & Prnt Svc	-0.001	-0.001	-0.001	-0.001	-0.001	-0.001	-0.001
Nav Pub Wrks Ctr: Utilities	0.038	0.038	0.038	0.038	0.038	0.038	0.038
Nav Pub Wrks Ctr: Pub Wrks	0.029	0.029	0.029	0.029	0.029	0.029	0.029
Naval Shipyards	0.057	0.057	0.057	0.057	0.057	0.057	0.057
Airlift Svcs Trng & Ops	0.380	0.380	0.380	0.380	0.380	0.380	0.380
Communications Svc	-0.131	-0.131	-0.131	-0.131	-0.131	-0.131	-0.131
Def Finance & Acct Svc	-0.027	-0.027	-0.027	-0.027	-0.027	-0.027	-0.027
Cost Reimbursible Svc	0.021	0.021	0.021	0.021	0.021	0.021	0.021
MAC Cargo	0.020	0.020	0.020	0.020	0.020	0.020	0.020

Budget Activity Group	IHC	PSC	CHS	IM	MA	E&T	BOS
MAC SAAM	-0.052	-0.052	-0.052	-0.052	-0.052	-0.052	-0.052
MSC Cargo	-0.010	-0.010	-0.010	-0.010	-0.010	-0.010	-0.010
MTMC Port Handling	0.045	0.045	0.045	0.045	0.045	0.045	0.045
MTMC Other	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Commercial Transportation	0.02	0.02	0.02	0.02	0.02	0.02	0.02
Civ Pay Reimburs Host	0.026	0.026	0.026	0.026	0.026	0.026	0.026
Foreign Nat Ind Hire	0.026	0.026	0.026	0.026	0.026	0.026	0.026
Separation Liability	0.026	0.026	0.026	0.026	0.026	0.026	0.026
Rental Pay to GSA	0.021	0.021	0.021	0.021	0.021	0.021	0.021
Purchased Utilities	0.021	0.021	0.021	0.021	0.021	0.021	0.021
Purchased Communica	0.021	0.021	0.021	0.021	0.021	0.021	0.021
Rents non GSA	0.021	0.021	0.021	0.021	0.021	0.021	0.021
Postal Svcs	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Supplies & Mat	**0.035**	**0.035**	0.021	0.021	0.021	0.021	0.021
Printing & Reproduct	0.021	0.021	0.021	0.021	0.021	0.021	0.021
Equipt Maint Contract	0.021	0.021	0.021	0.021	0.021	0.021	0.021
Facility Maint Contract	0.021	0.021	0.021	0.021	0.021	0.021	0.021
Pharmacy	0.101	0.101	0.101	0.101	0.101	0.101	0.101
Equipt Purchases	**0.035**	**0.035**	0.021	0.021	0.021	0.021	0.021
Overseas Purchases	0.021	0.021	0.021	0.021	0.021	0.021	0.021
Other Depot Maint	0.021	0.021	0.021	0.021	0.021	0.021	0.021
Contract Consultants	0.021	0.021	0.021	0.021	0.021	0.021	0.021
Mgmt & Prof Spt Svc	0.021	0.021	0.021	0.021	0.021	0.021	0.021
Studies Analysis Eval	0.021	0.021	0.021	0.021	0.021	0.021	0.021
Engineering Tech Svc	0.021	0.021	0.021	0.021	0.021	0.021	0.021
Fuel	0.097	0.097	0.097	0.097	0.097	0.097	0.097
Grants	0.021	0.021	0.021	0.021	0.021	0.021	0.021
Other Contracts	**0.070**	**0.070**	0.021	0.021	0.021	0.050	0.021
Other Costs	**0.035**	**0.070**	0.021	0.021	0.021	0.021	0.021

Defense Health Program Operation and Maintenance Appropriation Program Element Account Structure – Fiscal Year 2006 President's Budget ($000s)

Defense Health Program Operation and Maintenance Appropriation
Program Element Account Structure – Fiscal Year 2006 President's Budget ($000s)

In-House Care BAG

0807700	MEDCENs, Hospitals & Clinics (CONUS)	2,700,578
0807900	MEDCENs, Hospitals & Clinics (OCONUS)	258,361
0807701	Pharmaceuticals, In-House (CONUS)	1,753,317
0807901	Pharmaceuticals, In-House (OCONUS)	113,411
0807715	Dental Care Activities - CONUS	327,440
0807915	Dental Care Activities - OCONUS	57,233

Private Sector Care BAG

0807702	Pharmaceuticals - Purchase Health Care	182,133
0807703	Pharmaceuticals - National Retail Rx	1,537,925
0807723	TRICARE Managed Care Support Contracts	4,759,574
0807738	MTF Enrollees - Purchased Care	1,655,830
0807741	Dental - Purchased Care	252,449
0807742	USFHP	278,307
0807743	Supp Care - Health Care	744,174
0807745	Supp Care - MMSO Dental	118,687
0807747	CHE / CAP	186,782
0807749	Overseas Purchased Health Care	207,025
0807751	Misc Purchased Healthcare	270,770
0807752	Misc Support Activities	18,771

Consolidated Health Support BAG

0801720	Examining Activities	43,341
0807714	Other Health Activities	446,774
0807705	Military Public/Occupational Health	236,071
0807760	Veterinary Services	22,310
0807724	Military Unique - Other Medical	299,643
0807725	Aeromedical Evacuation System	54,412
0807785	AFIP	60,038

Information Management BAG

0807781	Service Medical IM/IT	366,102
0807793	Tri-Service IM/IT	475,452

Management Activities BAG

0807798	Management Headquarters	55,435
0807709	TRICARE Management Activity	171,522
0901200	BMMP Domain Management & Systems Integration	2,425

Education and Training BAG

0806722	HPSP	170,623
0806721	USUHS	95,541
0806761	Other Education and Training	177,298

Base Operations/Communications BAG

0806276	Facilities Restoration and Modernization - CONUS	132,086
0806376	Facilities Restoration and Modernization - OCONUS	51,480
0806278	Facilites Sustainment - CONUS Health Care	274,707
0806378	Facilites Sustainment - OCONUS Health Care	49,152
0807779	Real Property Services - CONUS	253,929
0807979	Real Property Services - OCONUS	24,991
0807795	Base Communications - CONUS	41,156
0807995	Base Communications - OCONUS	7,304
0807796	Base Operations - CONUS	249,449
0807996	Base Operations - OCONUS	24,893
0807753	Environmental Conservation	374
0807754	Pollution Prevention	597
0807756	Environmental Compliance	26,181
0807790	Visual Information Systems	11,084

Total DHP Operation and Maintenance **19,247,137**

Overview

The Private Sector Care (PSC) Requirements Model currently divides PSC into the following 12 Program Elements (PE's):

- 807702 TRICARE Mail Order Pharmacy (TMOP)

- 807703 Retail Pharmacy

- 807723 Managed Care Support (MCS) contracts (the recently awarded T-Nex regional MCS contracts, excluding Military Treatment Facility (MTF) Primary Care Manager (PCM) enrollee care and non-underwritten care)

- 807738 MTF PCM enrollee care for non-active duty (these costs are also included in the T-Nex MCS contracts' underwriting provisions, except for MTF enrollees in Alaska)

- 807741 Dental – non-active duty

- 807742 Uniformed Services Family Health Plan (USFHP)

- 807743 Supplemental Care - Health Care (primarily purchased health care for active duty)

- 807745 Supplemental Care – Dental (for active duty)

- 807747 Continuing Health Education/Capital Investment (CHE/CAP) payments made to civilian hospitals for a portion of their costs related to graduate medical education and capital investments

- 807749 Overseas Purchased Health Care

-807751 Miscellaneous Purchased Health Care (includes Reserve Select health care costs, demonstrations, and other miscellaneous health care cost items)

-807752 Miscellaneous Support Activities (e.g., the Marketing & Education contract, the National Quality Monitoring Program contract)

The PSC Requirements Model does not include costs associated with the DoD Medicare Eligible Retiree Health Care Fund.
The three most significant PE's are the MCS contracts (807723),

MTF PCM enrollee care for non-active duty (807738), and Retail Pharmacy (807703). These three PEs account for approximately three-fourths of the PSC total.

Underlying Contractor Health Care Costs:

- The most significant portion of the costs in the T-Nex MCS and retail pharmacy contracts is the underlying health care cost paid by the contractors to civilian providers.

- In developing its projected trends for these underlying health care costs, our analysis includes consideration of the following:

1. Recent trends in the contractors' health care costs (due to attraction of new users, volume trends, inflation);

2. Recent and projected trends in private sector employer health plans and the national health care sector in general; and

3. Effects of planned changes in the TRICARE program (benefit changes, change in provider reimbursement policies, contract transitions, etc.).

- Using our claims database, we decompose the historical trends in its underlying health care costs to determine what factors would be ongoing versus one-time effects. Factors accounted for include:

1. Global War on Terrorism (GWOT) effects (e.g., mobilized reservists, to be excluded from future projections);

2. Changes in the number of TRICARE eligibles under age 65 based on Defense Enrollment Eligibility Reporting System (DEERS) data;

3. Changes in the percentage of retiree eligibles under age 65 who actually use their TRICARE benefit (the "users" trend effect, discussed in more detail below); and

4. Changes in the cost per user (including changes in unit costs and volume of services per user).

- We assess these elements distinctly for pharmacy versus

non-pharmacy costs.

Attraction of New TRICARE Users:

• One of the trend effects we consider is the past and future trend in the percentage of TRICARE-eligible retirees and retiree family members under age 65 who actually use TRICARE rather than other health insurance (OHI), typically sponsored by the retiree or retiree spouse's current employer.

1. To measure this effect, we define a user as an individual with at least one MTF or TRICARE civilian physician visit during the year.

2. The most recent data indicate that the user rate among eligible retirees under age 65 and their family members increased approximately three percent in 2002, four percent in 2003, and four percent in 2004.

• This increasing users trend among retirees under age 65 is driven by two factors:

1. Private sector employer plans are increasing employee premium contributions, deductibles, copays, etc. Thus, employees' out-of-pocket costs are increasing, making OHI coverage less attractive to many retirees.

2. Meanwhile, TRICARE's benefit has become more generous and attractive over time. Recent benefit changes have lowered out-of-pocket costs for many services, and TRICARE has not raised its deductibles, enrollment fees, or remaining copays since the benefit was first implemented. Adding the TRICARE for Life (TFL) benefit also meant retirees no longer had to stay in their employer's OHI plan to qualify for an employer-sponsored "wrap-around" benefit once they became eligible for Medicare.

Trends in private sector employer health plans and the national health care sector.

• Evidence of civilian employer health plan cost trends is available from the Federal Employees' Health Benefit Plan (FEHBP) and several annual surveys of employer health plans.

1. FEHBP premiums increased 13% in 2002, 11% in 2003, 10% in 2004, and 8% (estimated) in 2005.

2. The annual Kaiser Family Foundation-Health Research and

Educational Trust survey indicates that health care costs among large, self-insured employers increased 9% in 2001, 12% in 2002, 12% in 2003, and 11% in 2004. Trends for self-insured employers are especially relevant because there is no effect from the "health insurance underwriting cycle."

• We also monitor trend projections made by the Centers for Medicare and Medicaid Services (CMS). Recent CMS projections are less relevant for TRICARE, however, because CMS's model assumes downward pressure on utilization trends because of employers raising deductibles, copays, etc., a dampening effect that would not apply to TRICARE.

Effects of Planned Changes In The TRICARE Program:

• We also make adjustments for a given year if significant program changes are planned. Examples can include benefit changes, changes in provider reimbursement policies, or scheduled contract transitions.

Projected Requirements For The Other PSC Program Elements:

• For the other PSC PE's, our requirements methodology:

1. Reviews actual historical expenditures and trends;

2. Adjusts this baseline for one-time effects; and

3. Applies future trend assumptions for the out-year projections.

STATEMENT OF
KATHI PATTERSON, FSA, MAAA
PRINCIPAL AND CONSULTING ACTUARY
MILLIMAN, INC.
BEFORE THE
COMMITTEE ON VETERANS AFFAIRS
U.S. HOUSE OF REPRESENATIVES

JUNE 23, 2005
*****

Mr. Chairman and Members of the Committee: I am pleased to be here this morning to discuss Milliman's role in the development of the Department of Veterans Affairs' (VA's) actuarial health care demand model. Mr. Chairman, if I may I would like to present a summary of my testimony and submit the longer version for the record.

Background

My name is Kathi Patterson and I am a principal and consulting actuary with Milliman, an international firm of actuaries and consultants. Milliman has been evaluating financial risk for clients since 1947. Our firm is broadly acknowledged to be the leading consulting firm to health care insurers and providers. Health care utilization and expenditure projections are at the core of the actuarial consulting that we, as health actuaries, provide to our clients. As a firm, we have served thousands of clients in the area of health care modeling, each effort with specific needs, characteristics, and applications.

Our health care clients consist of the majority of the health insurers in the nation, including Blue Cross Blue Shield plans, HMOs, and health insurance companies. In addition, our consultants provide cost modeling services to many health care providers, including hospitals, physician groups, pharmacy benefit managers, and other provider organizations. Our firm contracts with a number of governmental agencies to assist them with health care cost forecasting, including state Medicaid programs, state mental health agencies, state employee plans, state insurance departments, numerous county and municipal entities, and other federal agencies, such as Department of Defense and Centers for Medicaid & Medicare Services.

In addition to our direct client work, we have remained committed to conducting front-line industry research, and developing and maintaining a series of consulting tools that have shaped the way we measure health care costs and efficiency. One such tool that is integral to VA's actuarial health care demand model, referred to as the VHA Enrollee Health Care Demand Model, is our Health Cost Guidelines© (HCG) series, which was launched almost 50 years ago. Over the years the HCGs (now published in seven volumes) have become

an industry standard and are used in-house by more than 90 insurers in understanding or estimating expected health care insurance claim costs. Among the critical data recorded in the guidelines are utilization rates for specific health care services and variations in service costs observed within each state across the country. Traditional health carriers and managed care organizations use this information in product pricing. It also provides utilization benchmarks for managed risk arrangements.

Our firm also publishes the Health Cost Index® database, which provides measurements of national and regional monthly rates of increase in health care provider net revenues, capturing the impact of price, utilization, and mix/intensity changes in providing health care. The Index's database contains indices for hospital inpatient, hospital outpatient, physician, and prescription drug benefits. The research that goes into producing this publication has been a valuable resource while working with VHA to establish the trend rates used in the VA projection model.

VHA was in need of the expertise to develop a demand model. As actuarial consultants, we are frequently called upon to design and implement projection models for our clients, particularly when those models include elements of financial risk. Public and private health systems, even those with health actuaries on their staff, frequently use Milliman actuaries for their broad experience base and access to extensive research and data. A large consulting firm, such as Milliman, offers an extensive range of experts who specialize in all aspects of health care financial risk. In addition, an outside actuarial firm offers clients an external perspective deemed valuable to the client and its actuaries.

I have 19 years of health actuarial experience and I have been consulting with Milliman for the past 10 years. I am a Fellow in the Society of Actuaries and a member of the Academy of Actuaries. I have been involved with VHA as a consultant since 1996 when they first began exploring ideas on how to measure the impact of eligibility reform legislation. Moving from an inpatient-based system to a comprehensive health care network, Milliman and VA determined that historical costs were not necessarily appropriate to use for projecting future demands on the VA health care system. Until March of this year Milliman worked as a subcontractor to develop a health care demand projection model for VHA. As of March 2005, Milliman was awarded a direct contract with VHA to provide continued support for this model.

Over the years, VA and Milliman have developed a strong partnership. Milliman brings specialized expertise, access to extensive amounts of data, and first rate research to the modeling effort. VA experts provide valuable input to the majority of the individual analyses used to develop the model assumptions. In addition, VA experi-

ence data is incorporated into many of the analyses. This partnership of experts and data from both VA and Milliman is a powerful combination that provides VA with the best resources to develop an outstanding model.

General Health Care Projection Modeling Concepts

Traditionally, VHA developed expenditure forecasts based on trended historical expenditures. With the implementation of Eligibility Reform, the evolving VA health care system created the need for a more flexible and comprehensive enrollment, utilization, and expenditure projection model. Under eligibility reform, veterans, with some exceptions, are required to enroll in the VA health care system in order to receive health care services. The previous patient-based system was transformed into an enrollee-based system, similar to existing private and public sector health plans. Once enrolled, VA takes on the responsibility for providing the health care services requested by enrollees. Health plans/insurers have been dealing with the task of pricing their member- (enrollee-) based products since their inception and Milliman health actuaries have played a major role in developing the projection models needed to accomplish this task.

Generally, in an enrollee-based health care system, the carrier (in this case VHA) is financially responsible (except for any cost sharing requirements) for providing any covered health care services requested by the enrollee. Therefore, in order to estimate the expected future costs of the system, health care service utilization must be modeled for each covered enrollee, as well as the expected costs for providing each of those services. Within the health care system it is understood that some enrollees will not require any health care services, some will require low or medium cost services and a few will require very high cost services during any given year. Certain enrollee characteristics can be used to help predict these future health care needs, such as age and gender. The general concepts for modeling health care services and costs for an enrollee based health care system are outlined below.

Concept 1: Each enrollee in a health care system has a unique health care profile

Concept 2: Individual enrollee health care profiles change over time

Concept 3: New enrollees are continually entering and current enrollees are continually leaving (death or choosing another system such as Medicare) the health care system

Concept 4: A health care system is made up of all their enrollees with their respective health care profiles

Concept 5: A health care system can change policies (benefits, eligibility, delivery system, cost sharing, etc.)

Concept 6: VHA is a health care system

Concepts 1 through 5 must be considered when modeling the costs for a health care system because health care systems are not static. Each of these general modeling concepts are applicable to VHA, which is a dynamic health care system. For concept 1, the typical health care profile of a veteran patient of the VHA health care system prior to Eligibility Reform is different from the typical health care profile of today's veteran enrollee. The health care profiles of veteran patients and enrollees changes over time (Concept 2) due to such things as aging, life style, medical advances, etc. Concept 3 relates to the fact that a different mix of veterans was coming to VHA for services prior to eligibility reform than is coming today. Concept 4 refers to patients of VHA prior to eligibility reform and as well as veteran enrollees today. Policy changes under Concept 5 could impact the entire health care system.

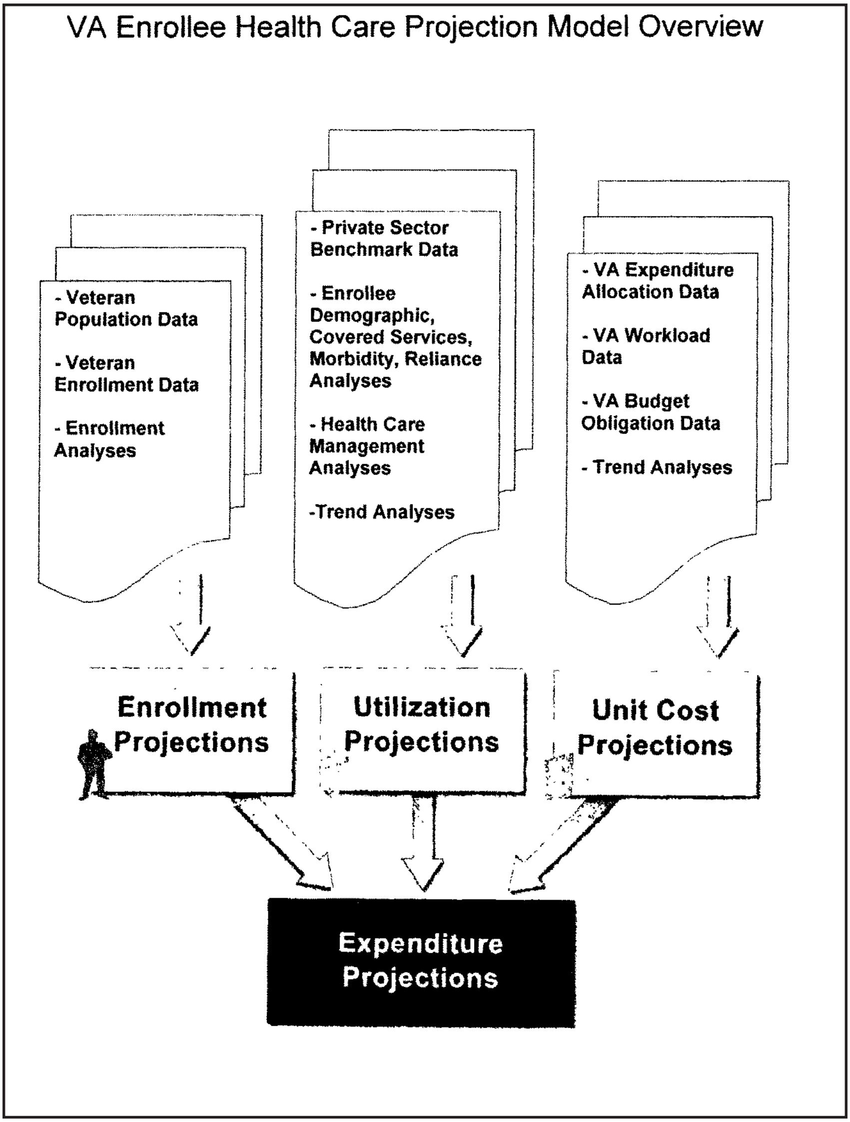
VHA is a dynamic health care system, therefore, it is appropriate to use generally accepted health care modeling techniques to forecast future health care expenditures. Historical budget forecasting methodologies previously used by VHA have extreme limitations in a dynamic environment. We have worked very closely with VHA to develop a demand model, employing the above modeling concepts, that reflects the unique characteristics of the veteran enrolled population, the unique characteristics of the VHA health care system, and other exogenous variables such as anticipated medical advances, inflation, technology, etc.

The resulting model is a set of very detailed health care utilization and expenditure projection models. We model multiple health care services separately for many different enrollee profiles (age, gender, priority level, etc.) and geographic regions. This produces over 40,000 individual utilization and expenditure models for each projection year. Given this level of detail, policy changes can be readily measured with this type of model.

Enrollment is projected using veteran population estimates, current enrollment levels, historical rates of enrollment, and enrollee mortality assumptions. The expenditure model, in general, begins with benchmarks that are adjusted to reflect the age, gender, reliance, and morbidity mix of the projected veteran enrollee population. They are also adjusted to reflect the VA benefit package, any enrollee cost-sharing, health care practice patterns specific to the VHA health care system and VA unit costs. The model assumptions are developed using both VA and non-VA data. For example, reliance, which measures the portion of an enrollee's total health care demand that is provided by VHA, is estimated using both VA and CMS data.

Annually, the model is updated and fine-tuned to ensure that the model reflects, as best possible, actual VHA expenditures. Milliman

and VHA regularly monitor model projections with actual outcomes. In addition, Milliman conducts an extensive model validation study. The results of this study identify any strengths and weaknesses of the model and provide information about how the model can be improved. These studies are also used to evaluate the impact of proposed or implemented model enhancements. The following graphic depicts the modeling process.



The expenditure projections produced by the model are used as the basis for the VHA budget process. The model assumptions can be modified to reflect various policy scenarios to measure the estimated impacts of these policies on projected enrollment, patients, workload, expenditure and cost-sharing revenue. The model also has the functionality to measure impacts of other factors such as changing economic conditions, future military conflicts, and policy changes impacting other private or public health care systems.

Conclusion

Mr. Chairman, in closing, I believe that the VHA Enrollee Health Care Demand Model is based upon sound health care projection modeling techniques and is appropriate for use in the budget formulation process. This completes my statement. I will be happy to respond to questions from the Committee.

STATEMENT OF
STEVE A. ROBERTSON, DIRECTOR,
NATIONAL LEGISLATIVE COMMISSION
THE AMERICAN LEGION
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
ON
THE BUDGET MODELING AND METHODOLOGIES USED BY
THE DEPARTMENT OF VETERANS AFFAIRS

JUNE 23, 2005

Mr. Chairman and Members of the Committee:

Thank you for this opportunity to participate in this important hearing to examine the budget modeling and methodologies used by the Department of Veterans Affairs (VA) in developing and forecasting veterans' health care costs and utilization projections for future years. The American Legion welcomes this chance to address its approach to health care modeling for VA.

The American Legion continues to advocate for adequate funding levels to ensure America's veterans receive the health care and benefits they have earned through their honorable service to this country. With young service members currently deployed to more than 130 countries, it is the responsibility of this Committee to ensure VA is indeed capable of meeting its obligation to provide for timely access to services for America's veterans that choose VA as their preferred health care provider. The American Legion commends the Committee for holding this hearing to discuss this important matter.

Former British Prime Minister William Gladstone once said, "Budgets are not merely affairs of arithmetic, but in a thousand ways go to the root of prosperity of individuals, the relation of classes, and the strength of kingdoms."

The basic difference between The American Legion's Department of Veterans Affairs' (VA's) budget recommendation and the President's VA budget request and the congressional VA budget is The American Legion's is demand-driven, whereas the other two are budget-driven. In fact, The American Legion's recommendations are probably more consistent with VA's initial submission to the Office of Management and Budget (OMB) before the initial "pass-back."

Mr. Chairman, of all of the budget modeling and methodologies available, the congressional budget process is the least effective in properly funding VA. Will Rogers said, "The budget is a mythical bean bag. Congress votes mythical beans into it, and then tries to reach in and pull real beans out."

VA's Office of the Assistant Secretary for Management is staffed with very competent professionals. However, Members of Congress and the American taxpayers are not getting their money's worth because the best product, the true budgetary needs of VA, is submitted to the Office of Management and Budget (OMB).

What Congress and the American people see is a skewed budget recommendation that meets the President's budget needs rather than the actual needs of VA; therefore, an inaccurate and unprofessional product. It is a challenge for Congress to build a good budget when even national priorities are tainted to meet artificial, bureaucratic, and political parameters.

Clearly, if Congress and the American people were allowed to see the initial budget recommendation, rather than the watered-down version, everyone involved in the budgetary process could work towards a solid product – supported by the President, Congress, and the American people. Nobody wants to shortchange America's heroes and their families.

For a moment, let's assume that the President's budget request accurately reflects VA's needs:

- Why is "timely access" a problem?
- Why are eligible veterans being denied enrollment?
- Why are third-party collections inadequate?
- Why create "an annual enrollment fee" for certain veterans?
- Why increase co-payments for certain veterans?
- Why do claims take so long to be processed?
- Why are there waiting lists for VA nursing homes?
- Why are there hiring freezes throughout VA?
- Why is medical inflation within VA viewed differently than medical inflation in the rest of the health care industry?

The American Legion believes the underlying answer to each of these questions is an inadequate funding paradigm. The American Legion does not advocate simply "throwing money at the problem" without any accountability; however, we do believe VA needs the fiscal resources to operate the very best system possible. Good budgeting should not be the homogeneous allocation of inadequate funding, but rather a solid statement of national priorities. Maintaining a strong

national defense is a top national priority, while VA is clearly an end-product of winning wars and maintaining peace.

It is the hope of The American Legion that eligible Members of Congress would want to seek their health care first from VA medical facilities rather than the Department of Defense or the private sector.

Clearly, there is a tremendous difference in the budgetary modeling and methodology between VA and DoD medical care. In the VA health care delivery system, not all veterans have equal access standards to quality health care, regardless of their willingness to pay. Currently, new Priority Group 8 veterans – those most likely to have resources and third-party insurance coverage – are denied enrollment regardless of their honorable military service in combat or peacetime.

Within DoD medical care, all eligible beneficiaries are welcomed to enroll and have equal access to timely health care within their assigned region. Active-duty service members are primarily taken care of within the Military Treatment Facilities (MTFs), while all other beneficiaries may be treated in MTFs or civilian health care facilities based upon their contracted health care provider's decision.

Likewise, trying to compare the enrollment fees for TRICARE Prime beneficiaries and proposed enrollment fees for Priority Group 7 and 8 veterans is an awkward and inaccurate comparison. All TRICARE Prime beneficiaries enjoy the same priority for care; whereas, Priority Group 7 and 8 veterans are at the end of the prioritization list for care and may very well exceed VA's own acceptable access standards.

The American Legion also recognizes that most military beneficiaries with veterans' status have earned the right to use both health care delivery systems. The decision is normally based on individual health care needs – for example, long-term care or other specialized care not available through DoD, TRICARE, or TRICARE for Life. However, there are recently separated military retirees (since January 2003) in Priority Group 8 that are currently denied enrollment in VA. To gain access, these veterans would have to be specifically referred to VA by TRICARE for Life via some kind of sharing agreement.

The American Legion's Budget Methodology

The American Legion's budget recommendations are based on both internal and external factors:

- Internal Factors

1. **A System Worth Saving** – findings from on-site visits to local VA medical facilities. The American Legion has spent a great deal of time, energy, and effort to get an “up close and personal” view of a patient’s experiences throughout the VA health care system. Preparation of this annual report is based on actual site visits to VA medical facilities. During these visits, both “official” and “unofficial” information is collected and documented. Clearly, there are problems – some fiscal and others managerial – but each problem can be resolved. In most cases, there are no “cookie-cutter” solutions, but there are two unquestionable trends – funding and staffing shortfalls.

2. **CARES Task Force** – reports from local veterans’ advocates closely monitoring activities, situations, and observations at local VA medical facilities. The American Legion created a CARES Task Force to work with VA personnel and other stakeholders during the entire life of the CARES study. This group of Legionnaires will continue to monitor the CARES process through-out the implementation phase. They continue to provide valuable input and assessments – such as reports of budgetary shortfalls in FY 05 and anticipated budgetary cuts in FY 06.

3. **Formal network of service-officers** -- The American Legion’s network of dedicated service-officers, at both the local and state level, have plenty of daily contact with veterans seeking assistance. Too often these service-officers see veterans experiencing major obstacles in receiving their earned benefits. Sometimes they need help with disability claims, while others need health care assistance, especially VA’s specialized services. Again, these service-officers report of problems encountered in assisting veterans in need.

4. **Formal network of homeless veterans’ program advocates and providers** -- The American Legion has a formal network of homeless veterans’ program advocates that share information of the challenges faced by homeless veterans they assist.

5. **Information from other advocacy organizations** -- The American Legion works closely with a number of veterans’ and military service organizations, health care professional organizations, and other such advocacy groups. We share information and observations with regard to not only VA funding, but services provided and the quality of health care delivered.

6. **Information from informed government sources** -- through close association with numerous government agencies and off-

icials, a great deal of information – official and unofficial – is collected by not only The American Legion's professional staff, but also Legionnaires actively engaged within their local community. Such information like OMB's "spring guidance" to all Federal budget offices and the Bureau of Labor Statistics' medical inflation rates are extremely useful.

- External Factors

1. **The President's Task Force to Improve Health Care Delivery For Our Nation's Veterans report** -- among the numerous findings of this Presidential Task Force was the mismatch between demand for services and available resources. Even the Task Force could not agree on "the best solution," but unanimously agreed that the issue needed immediate attention. As a result, several bills have been introduced offering possible solutions. The American Legion has joined ranks with 9 other major veterans' service organization in support of a full funding formula approach that would remove VA medical services from the annual discretionary appropriations process, such as Medicare, Social Security, VA compensation and pension, et al.

2. **President's budget request** -- provides a great deal of facts, figures, and statistics from the Office of the Assistant Secretary for Management. Although this document fails to reflect the "true" budgetary needs of VA and we disagree with many of its VA legislative initiatives contained therein, it reflects changes in funding, workloads, staffing, services, and other extremely useful information. The American Legion testifies before a joint session of the Veterans' Affairs Committees each fall with the goal of impacting the President's budget request as it is being crafted for presentation in February.

3. **Budget Resolution** -- provides The American Legion with the views and estimates of the Veterans' Affairs Committee, as well as the leadership of both sides of the aisle. The 5 or 10-year projections provide valuable insight.

4. **Annual VA appropriations** – serves as the platform for building the next fiscal year recommendations. Unfortunately, for the last three years, this bill has been a part of an omnibus appropriations bill enacted well into the new fiscal year. Clearly, this adversely impacts the long-range planning efforts of local VA medical center directors, medical researchers, as well as VISN Directors.

The American Legion's Health Care Modeling

In the late 1980s, The American Legion was deeply concerned with the health care delivery problems faced by veterans and military beneficiaries. Within VA, service-connected disabled veterans, economically disadvantaged veterans, and Civilian Health and Medical Program for VA (CHAMPVA) eligible beneficiaries were the only individuals with complex access standards to an inpatient-oriented health care delivery system. Military beneficiaries had to navigate an extremely costly and inefficient Civilian Health and Medical Care for Uniformed Services (CHAMPUS) program that failed to provide timely access. The American Legion believed there was a better way to meet the health care needs of America's veterans and their families. After much deliberation, The American Legion offered to Congress a new health care model for VA health care delivery in the 21st Century, it was called the GI Bill of Health.

Fundamentally, the GI Bill of Health called on Congress to create an integrated health care delivery system accessible to all veterans and their eligible family members. Building on VA's current infrastructure and contracting authority, VA would build a network of qualified health care providers working with its medical school affiliations; the military health care system; Public Health Service, to include Indian Health Services; the Federal Employee Health Benefit Program; and the Centers of Medicare and Medicaid Services (CMS); and contracted health care providers.

The GI Bill of Health called on the Veterans Health Administration (VHA) to establish an enrollment process accessible to all veterans and their eligible family members. Also, VHA would develop defined health benefit packages for basic care, comprehensive care, and specialized services.

Congress would authorize the creation of a Veterans Health Plan Fund to serve as a repository for all appropriated dollars (mandatory and discretionary), premiums, co-payments, coinsurance, deductibles, and third-party reimbursements. Funds would be expended for the timely delivery of health care services.

- **Mandatory vs. discretionary funding**. The American Legion points out that Title 38, United States Code (USC), clearly identifies priority veterans, non-priority veterans, and dependents of veterans. Congress mandates the Secretary of Veterans Affairs to provide health care services to certain priority veterans and dependents of veterans at no cost to the beneficiary. All other veterans and dependents should be required to cover the cost of their

health care services through premiums, co-payments, or third-party reimbursements.

The American Legion believes the funding needed to provide the care required to those priority veterans and dependents of veterans should be guaranteed (mandatory funding). However, this does not relieve Congress of its responsibilities of appropriating discretionary appropriations for other VHA costs, such as medical facilities, medical administration, homeless veterans, and other such discretionary programs.

- **Medicare reimbursements.** Under current law, VA is prohibited from billing Medicare for the treatment of nonservice-connected medical conditions of enrolled Medicare-eligible veterans. Medicare eligibility is not a criteria for enrollment in the VA health care delivery system; therefore, VA is funded to treat Medicare-eligible veterans. When Medicare is listed as the veteran's health insurance provider, VA should be authorized to bill CMS for the treatment of allowable nonservice-connected medical conditions just as any other health care provider (just like DoD's TRICARE for Life or PHS' Indian Health Services).

- **Third-party reimbursement offsets**. Third-party reimbursements are essential for VA to meet its budgetary requirements. The current practice of offsetting third-party collections from the discretionary appropriations puts each VA medical facility in the "red" pending future collections. As previously mentioned, VA's inability to collect from CMS is a major obstacle since over half of VA's enrolled patient population is Medicare-eligible. In addition, VA's current Medical Care Collection Fund's inability to achieve the projected collection goal is unacceptable and must be corrected.

- **Enrollment**. Enrollment is a critical element of the GI Bill of Health because it identifies not only who is enrolled, but more importantly, how that medical care will be paid for. For priority veterans and dependents of veterans, they will identify VA as the primary payer and any third-party insurers. Military beneficiaries would identify DoD and any third-party insurers. Non-priority veterans and dependents of veterans would identify their third-party insurers. For veterans and dependents with no third-party insurers, VA should be authorized to offer premium-based health benefit packages (similar to TRICARE or FEHBP).

- **Defined health benefit packages.** The GI Bill of Health called for defined benefits packages so that veterans and dependents

would understand health care services available to them under each benefit package. VA would offer a basic plan, comprehensive plan, and specialized services plan(s). At enrollment, each enrolled veteran or dependent would be placed in the appropriate health benefit plan(s).

• **Timely access standards**. Under the GI Bill of Health, all veterans would be subject to VA's own timely access standards. To achieve this objective, VA will have to closely monitor appointments and patient populations. With VA's transformation to integrated care, the number of outpatient clinics has grown dramatically. With the addition of a more diverse patient population with a significant increase in women and children, VA will need to adjust its own health care professional staffing and contracted services.

• **Availability of services.** The GI Bill of Health emphasizes the timely delivery of quality health care in the most appropriate setting. This philosophy is consistent with the overall objective of the Capital Assets Realignment for Enhanced Services (CARES) program. Throughout the 1990s in the midst of VA's transformation, hundreds of community-based outpatient clinics were opened to move health care delivery closer to where veterans lived. The American Legion believes VA should collaborate with other Federal health care providers where opportunities expanding VA health care services may be practical, especially in rural areas. Working in close co-ordination with DoD's Base Realignment and Closure Commission, the availability of military medical facilities destined for closure many present opportunities for future community based outreach clinics, especially if there is a large military retirement community in the catchment area.

• **VERA formula.** One of the major problems with the current Veterans Equitable Resource Allocation (VERA) formula is that it ends at the VISN rather than the facility levels. This flawed process allows the VISN director to withhold resources that were allocated based on the criteria determined by the individual medical facilities within the VISN. Allocated dollars should not be held in reserve accounts – each facility should receive its earned allocation.

Conclusion

Mr. Chairman and Members of the Committee, The American Legion's Medical Care Modeling is designed to:

- Enable the Veterans Health Administration to provide time-

ly access to quality health care for all enrolled patient population;

- Assure all enrolled patients identify means of payment for their health care treatment;
- Assure adequate funding through Federal appropriations (both direct and discretionary), co-payments, premiums, and third-party reimbursements from Federal and private health insurers;
- Assure all service-connected disabled veterans have timely access to quality health care for treatment of their service-connected condition at no cost to the veteran;
- Increase the number of access points for VA health care services;
- Assure all enrolled patients are assigned to the appropriately defined health benefits package(s);
- Eliminate unnecessary, duplicative, or contradictory regulations that would hamper timely access to quality health care services;
- Expand the diversity of VA patient population; and
- Continue to honor the military service of those enrolled veterans, survivors, and other family members.

Mr. Chairman, VA, Congress, and The American Legion share the same goal – meeting the needs of America's veterans and by working together, we can achieve that goal. This concludes my testimony and I appreciate this opportunity to present The American Legion's approach to health care modeling.

PVA
PARALYZED VETERANS
OF AMERICA

Statement of

Douglas K. Vollmer
Associate Executive Director for Government Relations
Paralyzed Veterans of America

Before the

House Committee on Veterans' Affairs

Regarding

VA Health Care Budget Medical Modeling
And
The Independent Budget

June 23, 2005

Mr. Chairman, Ranking Member Evans and members of the Committee, Paralyzed Veterans of America (PVA) appreciates this opportunity to present our views and experience on the methodology used in formulating the annual recommendations contained in *The Independent Budget* for funding veterans' programs and services. In

general, I will keep my remarks centered on the major budget accounts supporting the provision of VA medical care.

The first *Independent Budget* was published 19 years ago. Former VA Chief Medical Director, and Surgeon General of the Navy, retired Vice-Admiral, Donald Custis, M.D. suggested that the four veterans' service organizations, AMVETS, Disabled American Veterans, Paralyzed Veterans of America and Veterans of Foreign Wars form a unique partnership to develop and publish yearly VA budget views and estimates. The resulting Independent Budget should be used, he strongly felt, to demonstrate the actual financial needs of VA health care and other programs in the face of Administration budget requests and Congressional appropriations that were far too often influenced more by political considerations and the changing pressures of federal budget policy than by objective medical budget modeling.

Under Admiral Custis' leadership, PVA took the primary role, as it does today, in developing the annual budget recommendations for VA medical care accounts utilizing the professional services of health policy analysts and budgeters in our Health Policy and Government Relations programs.

The Independent Budget presents a "full budget model." It is the same model that VA uses at the beginning of its annual budget process attempting to assess what its current costs are in providing health care, and what, based on many different factors, its projected full need will be in the coming fiscal year. The VA and the Administration

generally abandon this process at this point in the give and take of the several budget submissions and budget pass backs to VA with instructions from the Office of Management and Budget to trim and sculpt the following year's request to meet overall federal budget growth guidelines, restrictions and VA legislative and policy directives. At this point the VA budget leaves the arena of pure budget modeling and enters the long road through the Congressional budget and appropriations process, as being shaped by "what the freight will bear" in the competition for funding with all other domestic discretionary programs.

The *IB* does not take that course. It simply takes the amount of the current year appropriations and adds to each account assumptions regarding inflation and salary increases to arrive at a current services estimate for the upcoming year. This current services estimate uses budget object classifications to more accurately tailor percentage increases. The current services baseline is a commonly understood concept in Congress. In fact, the Congressional Budget Office, (CBO) is mandated by law to treat discretionary spending in what is essentially a current services model (called a "current law" model).

Under the 1985 Act (Balanced Budget and Emergency Deficit Control Act of 1985) CBO must assume that the most recent year's budget authority is provided in each future year budget, adjusted using specific price indexes to offset projected inflation and to allow for such factors as cost-of-living adjustments for federal workers. (CBO "Economic

and Budget Issue Brief," June, 2005, "What is a Current-Law Economic Baseline," Table 1).

Therefore, a current services estimate, or a current law estimate, provides a baseline that presents a theoretical value of what it would cost to provide the same level of services in the following year as was provided in the current year. From that point, the *IB* presents an estimate as to the cost of individual recommendations found within the document such as increased FTEs, increased patient loads, and changes to current policies. These changes, a normal part of any rational budget process, are rarely completely documented or accounted for in final VA budget and appropriations.

Recent changes in the VA accounting structure, budget presentations and appropriations models have changed the actual budgeting format for final appropriations. What used to be called the Medical Care line item has now been divided into four parts: Medical Services, Medical Management, Medical Facilities and Medical and Prosthetic Research. The *IB* has adjusted to this change, although the transition has not always been easy to split what was once a single account into scores of VA budget object classifications including the minutia of personnel, travel, communications, printing, equipment, supplies, grants, collections, maintenance, leases, transfers, etc. and put them back together in four categories rather than just one. However, it can be done.

I am attaching a White Paper, "*The Independent Budget* – Methodology Used in Creation of Independent Budget Recommendations," prepared and submitted to the Committee at the request of the Chairman earlier this year. The paper provides additional technical detail as to how we assess the impact of annual wage and salary increases as well as formulas for estimating the affect of general inflation and other specialized inflation indices on VA budget accounts.

In closing, PVA, on behalf of the other *Independent Budget* veterans' services organizations, believes we can present and defend the full funding methodology that provides our annual recommendations. By contrast, any similar medical model that VA itself might put forward in initial recommendations for the following fiscal year becomes muddied in the actual ensuing budget and appropriations process that follows. VA and OMB must negotiate throughout the year over what those numbers mean. The final version of the budget that the Administration brings forward every year in February is only a composite of what the Department needs and what any administration would like to see it have. Overall budget increase requests are artificially skewed, claiming so-called "increases" that are only unrealistic management efficiencies tagged onto the budget as "increases." Budgets are inflated by equally unachievable third party collections. Administrations inflate budgets with additional "increases" from savings or legislative initiatives well known to be politically unattainable. In terms of real requests for real additional appropriations most administrations submit budgets on the cheap; they use no real medical model, and leave it to the Congress to try to make the fix. Sometimes this happens, and some times it does not, depending on the political and

THE INDEPENDENT BUDGET

A Budget for Veterans by Veterans

www.independentbudget.org

Methodology Used in Creation of *Independent Budget* Recommendations

Generally, for *Independent Budget* recommendations, we take the amount of the current year appropriation (in this case FY 2005) and add to each account assumptions regarding inflation and wage and salary increases in order to arrive at a current services estimate for the upcoming year (in this case FY 2006). This current services estimate uses budget object classifications to more accurately tailor percentage increases. A current services estimate merely provides a snapshot of what resources are needed in the upcoming year to meet the same needs as the current year. In certain accounts we have estimated to the best of our ability additional costs attributable to specific *Independent Budget* recommendations in order to arrive at the *Independent Budget* recommended amount. In certain VBA subaccounts included within the GOE account, we have taken a three-year average of reimbursable amounts and subtracted these from initial inflated amounts in order to come up with a "current services" estimate. For Medical Care, the *Independent Budget* estimates for Medical Administration and Medical Facilities accounts are the current services estimates; for Medical Services, estimates for the enrollment of Priority 8 veterans, increased demand, and an additional amount for specialized services and programs were added to the current services estimate in order to arrive at the *Independent Budget* recommended amount. All *Independent Budget* recommendations are for appropriated dollars only.

For the FY 2006 *Independent Budget*, in the area of wage and salary increases, we have taken the current year increase of 4.5 percent, and annualized this amount with the estimated FY 2006 increase of 3.5 percent. This amount is slightly higher than the Administration's estimate of 3.1 percent for "Federal pay raises, military" contained in the Economic Assumptions Table in the Analytical Perspectives volume of the FY 2006 budget submission. This same volume for FY 2005 estimated this increase at 4.15 percent, which underestimated the FY 2005 amount by .35 percent. It is necessary to annualize this increase due to the operation of the fiscal year as compared to the calendar year. Since FY 2006 will contain one fewer compensable day than FY 2005 (as noted in OMB Circular A-11 (2004) Section 32-5), we have also subtracted a suitable percentage from this annualized percentage amount to reflect this (FY 2006 contains a total number of compensable hours of 2,080 as compared to a FY 2005 total of 2,088, necessitating a decrease of .38 percent). For *Independent Budget* recommendations calling for increased FTE, we have taken average compensation amounts listed in the current year (FY 2005) budget submission, increased by the wage and salary percentage increase, and multiplied this average by the number of proposed FTE. Although this method perhaps under-estimates these costs, it provides us with a rough estimate in order to cost various recommendations.

As for general inflation, we have estimated a 3.5 percent increase over the course of the fiscal year, and for medical inflation a 5.2 percent increase. The general inflation estimate is slightly higher than the percentage increase in Consumer Price Index –All Urban (CPI-U) over the course of the last twelve months as reported by the Bureau of Labor Statistics on January 19, 2005. This amount is listed as 3.3 percent, for the twelve-month period ending December, 2004. The Administration has estimated a 2.3 percent increase for calendar-year 2006 (see the Economic Assumptions Table in the Analytical

Perspectives volume of the FY 2006 budget submission). It should be noted that in its 2005 budget submission, the Administration estimated the 2004 calendar-year rate of inflation at 1.4 percent, nearly 2 percentage points lower than the percentage increase as reported by the Bureau of Labor Statistics. The slight increase over the 2004 percentage change represents concerns over the effect of energy costs and dollar valuation over the course of FY 2006. The medical inflation estimate reflects increasing percentage increases over the last two years and the absence of any macroeconomic or microeconomic rationale to slow or reverse this trend.

As you can see, *The Independent Budget* recommendations are indeed conservative estimates, and do not even begin to address the impact of previous budgetary shortfalls on the VHA. If these shortfalls were to be addressed, the *Independent Budget* recommendation would be substantially higher.

PVA
PARALYZED VETERANS OF AMERICA

DOUGLAS K. VOLLMER
Associate Executive Director for Government Relations

Doug Vollmer, PVA Associate Executive Director for Government Relations, began his employment with PVA on July 1, 1979. Upon receipt of an undergraduate degree from Northwestern University in 1967, Doug entered the U. S. Navy and was commissioned in May 1968. He served in Vietnam with the River Patrol Forces and as a liaison officer with elements of the 5th Special Forces from November 1968 to October 1969. This service was followed by twenty months on the staff of the Assistant Chief of Staff for Intelligence, CINCPACFLT after which he returned to civilian life. Prior to joining PVA he received a Masters Degree from the University of Hawaii and pursued post-graduate study at the University of Maryland. During his twenty-six years at PVA, Doug has been involved with a broad range of veterans and disability rights issues of concern to PVA's members. He was named Associate Executive Director for Government Relations in 1989. Doug and his wife Scottie live in Washington, DC, they have a son, Zachary, who is currently a student in New York City.

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Information Required by Rule XI 2(g)(4) of the House of Representatives

Pursuant to Rule XI 2(g)(4) of the House of Representatives, the following information is provided regarding federal grants and contracts.

Fiscal Year 2005

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $228,000 (estimated).
Paralyzed Veterans of America Outdoor Recreation Heritage Fund – Department of Defense – $1,000,000.

Fiscal Year 2004

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $228,000 (estimated).

Fiscal Year 2003

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $228,803.

Testimony of Timothy J. Feeser, F.S.A.

Principal

Reden & Anders, Ltd.

For

The U.S. House of Representatives Committee on Veteran's Affairs

Hearing on

"Veterans Affairs Health Cost Forecasts"

June 23, 2005

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Table of Contents

I. Introduction

INTRODUCTION

Mr. Chairman and distinguished members of the Committee on Veterans Affairs, we appreciate this opportunity to testify before you on the private sector approach to healthcare expense forecasting. I am Tim Feeser, a principal with Reden & Anders, Ltd. (R&A), a national actuarial, clinical and management consulting firm specializing in financial and business decision support for the health care industry. We work with a full range of clients: managed care companies, insurance carriers, health care providers, employers, employer coalitions, medical device manufacturers and pharmaceutical companies. We have long-standing relationships with many of our clients and have built a reputation for credibility, creativity and outstanding service. Our professional staff includes credentialed actuaries, clinical consultants, underwriters, strategy and operations experts and researchers.

R&A is the consulting division within Ingenix, the information technology company owned by UnitedHealth Group (UHG).

R&A has been asked to discuss its methods to develop projected medical expense budgets for health plan clients. For purposes of our discussion, we will discuss the development of projected medical expenses for a fictitious health plan called ABC Health Plans (ABC).

Specifically, this report will address the following:

- Explanation of performing the historical experience analysis, including the overall methodology, lag analysis, allocation of medical expenses into common expense categories.
- Details regarding the development of medical expense trend assumptions.
- Illustrate the process of projecting medical expenses from a historical period to the forecasted period.
- Discussion of emerging techniques in the medical expense forecasting process.

The remainder of this report will outline the details undertaken in preparing the projected medical expense budget for ABC. We note that the numerical data presented in the exhibits is sample data prepared to illustrate the forecasting process.

II. Historical Experience Analysis

METHODOLOGY

In order to project the calendar year 2006 medical expense budget for ABC, it is necessary to develop baseline medical expense levels over recent historical time periods for key groupings of medical expense categories. In order to develop baseline historical medical expenses, we collected the following information from ABC:

- Claims experience for dates of service beginning January 2003 through December 31, 2004, with paid claims runout through April 30, 2005.
- ABC enrollment summaries over the January 2003 through December 2004 timeframe.
- Information regarding contractual changes with network facility providers.
- Information regarding average physician reimbursement levels and expected future changes.
- Information regarding any provider capitation arrangements and expected future changes.

Based on the aforementioned informational items, we developed experience summaries for ABC for calendar years 2003 and 2004.

Using the claims information provided by ABC, we developed experience summaries by major expense category classification, including inpatient facility services, outpatient facility services, physician/other services and pharmacy services. Paid claims triangles were also extracted from the claims experience to coincide with the major expense category groupings (i.e., inpatient facility, outpatient facility, and physician/other) in order to develop aggregate completion factor adjustments to the baseline experience.

LAG ANALYSIS

In order to develop completion factors to be used in converting the paid claims experience to an incurred basis, we sorted the ABC paid claims data into paid claims triangles for inpatient facility, outpatient facility and physician/other services. Dates of service were for the January 1, 2003 through December 31, 2004 timeframe, with payments through April 30, 2005. The averaging method used to calculate the completion factors was a four of six modified arithmetic method.

A completion factor represents how complete total expected claims are at a given point in time.

Historical Experience Analysis (cont'd)

COMMON EXPENSE CATEGORIES

In order to ensure ongoing flexibility in the medical expense budget forecasting process, it is important to summarize medical expenses into defined expense categories to allow for appropriate application of the following:

- Medical expense trends
- Changing benefit levels
- Ad hoc adjustments that could affect projections that should be considered

Development of common categorizations of medical expenses is intended to provide the specificity necessary in order to allow for greater flexibility in the medical expense budget projection process.

Common hospital inpatient categories are defined by bed type, including medical, surgical, complex newborn and delivery stays. In addition, separate expense line items are provided for mental and substance abuse services, as well as skilled nursing facility services. However, if mental and substance abuse services are provided by a specialty vendor, they are excluded from the experience analysis.

For hospital outpatient facility services, medical expenses are grouped into categories of care based on the main reason for the visit. Common hospital outpatient categories include emergency room services, laboratory and radiology services, observation room visits, outpatient surgeries and all other outpatient services.

Common medical expense groupings of physician/other services are based on groupings of CPT codes allowing pricing of current procedural terminology (CPT) codes as published by the American Medical Association.

Prescription drug services are all grouped together as a single line item in a standard budget model, although greater off-line analysis is performed at the therapeutic class level.

Exhibits A.1 and A.2 provide the details of the experience summaries for the common categories discussed above for calendar years 2003 and 2004. The completion factors used to convert paid claims experience to an incurred basis are also shown. For each of the medical expense category groupings, utilization per thousand rates, allowed cost per service figures and calculated allowed PMPM numbers are shown. In addition, net paid PMPM for each of the line items is shown and the resulting implied plan benefit factor, which is the ratio of the net paid PMPM to the allowed PMPM.

Historical Experience Analysis (cont'd)

MEDICAL EXPENSE SUMMARIES

Table 1 provides a summary of the ABC experience for calendar years 2003 and 2004, along with the implied experience trends in calendar year 2004 from calendar year 2003.

TABLE 1
SUMMARY OF ABC EXPERIENCE

	CY 2003 PMPMs			CY 2004 PMPMs			
	Allowed	Paid	Benefit Ratio	Allowed	Paid	Benefit Ratio	Paid Trend
Inpatient	$39.78	$38.61	.971	$43.57	$42.36	.972	9.7%
Outpatient	45.72	42.84	.937	50.80	47.76	.940	11.5%
Physician/Other	59.41	48.71	.820	62.71	51.54	.822	5.8%
Pharmacy	61.11	43.33	.709	67.83	49.34	.727	13.9%
Total	$206.02	$173.50	.842	$224.91	$191.00	.849	10.1%

In Exhibit A.2, note that a comparison of the experience trends on an allowed and paid basis show the paid trend to be slightly higher. This is due to what is called leveraged trend associated with a flat deductible and coinsurance benefit plan. The amounts that the insured member pays are constant (i.e., reflect zero trend) while the cost of medical services the plan pays continue to rise. Hence, the plans share of total medical expenses increases while the insured members share decreases into future periods.

III. Medical Expense Trend Analysis

INPATIENT HOSPITAL

To forecast medical expense trend, it is important to consider future changes to provider reimbursement contracts, either known or reasonable expectations as to what they might be and their associated impact.

In evaluating inpatient unit cost trend, information regarding current and changing hospital contracts is collected for key high volume network hospitals. In order to assess the relative impact on inpatient facility unit cost trend, evaluations of the change in reimbursement terms is performed through the use of analytic models. Payment terms within the contracts are evaluated both on a pre and post payment change basis. The relative percentage expected change due to updated payment rates at the particular facilities analyzed is used as an annual rate of trend for the given facility.

Based on the weighted days volume over the experience period, we developed a blended average expected trend rate for inpatient facility unit cost.

Details regarding the average annual trend assumptions for all hospitals can be found in Exhibit C. The 8.3% composite trend assumption for unit costs was used in the projection of inpatient facility expense for calendar year 2006. It should be noted that the 8.3% composite trend is based on ABC's inpatient volume mix across facilities during calendar year 2004.

A common practice in contracting with hospitals is to negotiate rates for two to three years. One will notice that for certain hospitals, a higher level of trend will be experienced in a given year, with smaller increases forecasted thereafter. This is because at the onset of a newly signed contract, there is often some catch up on the part of the hospital increasing their rates in the first year of a new three year contract with the plan.

OUTPATIENT HOSPITAL

The process used to assess trends for outpatient facility services is analogous to the process described above for inpatient facility services. In developing annual trend rate assumptions for outpatient facility services, an evaluation of the change in reimbursement terms is performed through the use of analytical models. Payment terms within the contracts are evaluated both on a pre and post payment change basis. The relative percentage of expected change, due to updated payment rates at the particular facilities analyzed, is used as an annual rate of trend for the given facility.

Exhibit D provides details regarding the development of the outpatient hospital annual unit cost trend across all hospitals.

Medical Expense Trend Analysis (cont'd)

Physician Services

The process used to assess trends for physician/other services is done more at an aggregate level, due to the sheer volume of physicians being substantially greater than the number of contracted facilities. ABC, as most other health insurers across the county, reimburse physicians a multiple of the Medicare fee schedule.

Analytical models that compare changes in the Medicare fee schedule year-to-year are used to evaluate the changing relative value units (RVUs) by CPT code. Published reports regarding prospective changes in the Medicare fee schedule are tracked and considered in evaluating trends for physician unit costs. Exhibit E provides a high level summary of physician unit cost trend analysis.

Pharmacy Services

The process used to determine unit pricing trend for prescription drugs is done separately for brand name and generic prescriptions (scripts). Changes to discounts from average wholesale price (AWP) are considered, along with anticipated increases in pricing for brand name and generic drugs. Future shifts to generic scripts are also considered, based on emerging availability of new lower cost generic drugs.

Exhibit F provides a summary of the development of the annual trend for average ingredient cost per script for brand and generic scripts.

Utilization Trends

For the utilization trend component, we believe relying on what we have seen within the industry to be a good proxy for most health plans in general, especially smaller plans where year-to-year experience can be volatile. Where specific changes are occurring within a given health plan's network, greater attention may be placed on particular expense category components. For larger plans, relying on their historical experience is the best indicator, factoring in any known circumstances specific to the plan that should be considered.

IV. Projected Medical Expense Budget for Calendar Year 2006

Based on ABC's actual experience over calendar year 2004, in conjunction with the estimates of annual trend, a projected medical expense budget for calendar year 2006 is developed. Table 2 provides a summary of the projections.

TABLE 2
SUMMARY OF PROJECTED MEDICAL EXPENSE FOR CALENDAR YEAR 2006

	CY 2004		CY 2006		Annualized Trend	
Medical Expense	**Allowed**	**Paid**	**Allowed**	**Paid**	**Allowed**	**Paid**
Inpatient	$43.57	$42.36	$52.14	$50.95	9.4%	9.7%
Outpatient	50.80	47.76	65.99	62.57	14.0%	14.5%
Physician/Other	62.71	51.54	71.05	59.00	6.4%	7.0%
Pharmacy	67.83	49.34	91.68	66.69	16.3%	16.3%
Total	$224.91	$191.99	$280.86	$239.21	11.7%	11.9%

Exhibit B provides greater detail of projected allowed and paid medical expenses for calendar year 2006. The annual trend rates used in projecting the allowed expenses are also shown in Exhibit B.

For this example, we note that we did not make changes to the underlying benefits in developing these projections. Hence, Table 2 shows the ongoing effect of leveraged trend on a non-changing deductible and coinsurance plan with paid trend .2% higher than allowed trend.

V. Emerging Techniques in Medical Expense Forecasting

Due to improving technologies in the healthcare data collection efforts of health insurers, more advanced techniques have emerged in how health insurers analyze past trends and forecast future trends.

Some advanced recent practices are as follows:

- The tracking of emerging medical technologies and quantification of their estimated use and cost impact on future trends.
- The tracking of emerging higher cost brand name drugs, when they will hit the market, and quantification of their use and cost impact on future trends.
- The tracking of brand name drug patents expiring and factoring in the use of cost impact on lower priced generic equivalent drugs.
- Greater focus on analyzing the relative disease state of a health insurers covered lives and the associated.

Continued advances in how the healthcare industry uses technology could lead to ongoing advancements in medical expense trend forecasting capabilities over time.

VI. Conclusion

In conclusion, projecting medical expense budgets for private sector health plans is a multi-step process involving analysis of historical experience, quantification of estimated trends and their application in the projections. Again, thank you for the opportunity to testify on this important topic. I would be happy to answer any questions you might have for me.

Exhibit A.1
ABC Health Plan
Summary of Claims Experience

Experience Period: Calendar Year 2003
Member Months 900,000

Service Category	2003 Claims Paid Through April, 2005 Days	Allowed	Member Cost Share	Plan Paid	Incurred Adjustment Factor	Completed Util/1000	Allowed per Util	Allowed PMPM	Cost Share PMPM	Plan Paid PMPM	Implied Benefit Ratio
Hospital Inpatient											
Medical/Surgical	18,000	30,000,000	900,000	29,100,000	1.000	240.00	1,666.67	33.33	1.00	32.33	0.970
Maternity	3,000	5,000,000	150,000	4,850,000	1.000	40.00	1,666.67	5.56	0.17	5.39	0.970
Complex Newborn	1,200	500,000	-	500,000	1.000	16.00	416.67	0.56	-	0.56	1.000
Subtotal	22,200	35,500,000	1,050,000	34,450,000		296.00	$ 1,599.10	39.44	1.17	38.28	0.970
SNF	800	300,000	-	300,000	1.000	10.67	375.00	0.33	-	0.33	1.000
Subtotal Hospital Inpatient	23,000	35,800,000	1,050,000	34,750,000		306.67	$ 1,556.52	39.78	1.17	38.61	0.971
Hospital Outpatient											
Emergency Room	8,000	8,000,000	600,000	7,400,000	1.000	106.67	1,000.00	8.89	0.67	8.22	0.925
Laboratory/Pathology	14,000	3,000,000	180,000	2,820,000	1.000	186.67	214.29	3.33	0.20	3.13	0.940
Radiology	21,000	10,000,000	600,000	9,400,000	1.000	280.00	476.19	11.11	0.67	10.44	0.940
Surgery	8,000	20,000,000	1,200,000	18,800,000	1.000	106.67	2,500.00	22.22	1.33	20.89	0.940
All Other	11,000	150,000	10,000	140,000	1.000	146.67	13.64	0.17	0.01	0.16	0.933
Subtotal Hospital Outpatient	62,000	41,150,000	2,590,000	38,560,000				45.72	2.88	42.84	0.937
Physician/Other Services											
Surgery - Non-Maternity	42,000	10,000,000	1,800,000	8,200,000	1.000	560.00	238.10	11.11	2.00	9.11	0.820
Surgery - Maternity - Non-Delivery	10,000	125,000	22,500	102,500	1.000	133.33	12.50	0.14	0.03	0.11	0.820
Surgery - Maternity - Delivery	1,500	950,000	171,000	779,000	1.000	20.00	633.33	1.06	0.19	0.87	0.820
Anesthesia	8,500	3,500,000	630,000	2,870,000	1.000	113.33	411.76	3.89	0.70	3.19	0.820
Radiology	85,000	5,000,000	900,000	4,100,000	1.000	1,133.33	58.82	5.56	1.00	4.56	0.820
Pathology/Lab	240,000	4,000,000	720,000	3,280,000	1.000	3,200.00	16.67	4.44	0.80	3.64	0.820
E&M - Office Visits	225,000	13,000,000	2,340,000	10,660,000	1.000	3,000.00	57.78	14.44	2.60	11.84	0.820
E&M - Preventive Medicine	17,000	1,400,000	252,000	1,148,000	1.000	226.67	82.35	1.56	0.28	1.28	0.820
E&M - Inpatient Visits	20,000	1,450,000	261,000	1,189,000	1.000	266.67	72.50	1.61	0.29	1.32	0.820
Consultations	15,000	1,850,000	333,000	1,517,000	1.000	200.00	123.33	2.06	0.37	1.69	0.820
Emergency Room/Critical Care	12,000	900,000	162,000	738,000	1.000	160.00	75.00	1.00	0.18	0.82	0.820
Ophthalmology - Exams	7,000	600,000	108,000	492,000	1.000	93.33	85.71	0.67	0.12	0.55	0.820
Ophthalmology - Services	3,500	210,000	37,800	172,200	1.000	46.67	60.00	0.23	0.04	0.19	0.820
Cardiovascular	18,000	1,150,000	207,000	943,000	1.000	240.00	63.89	1.28	0.23	1.05	0.820
Allergy	17,500	250,000	45,000	205,000	1.000	233.33	14.29	0.28	0.05	0.23	0.820
Imm/Inj	45,000	950,000	171,000	779,000	1.000	600.00	21.11	1.06	0.19	0.87	0.820
Physical Medicine	20,000	475,000	85,500	389,500	1.000	266.67	23.75	0.53	0.10	0.43	0.820
Accidental Dental	500	125,000	22,500	102,500	1.000	6.67	250.00	0.14	0.03	0.11	0.820
Ambulance	1,500	385,000	69,300	315,700	1.000	20.00	256.67	0.43	0.08	0.35	0.820
DME	11,500	1,550,000	279,000	1,271,000	1.000	153.33	134.78	1.72	0.31	1.41	0.820
Home Health	16,000	1,425,000	256,500	1,168,500	1.000	213.33	89.06	1.58	0.29	1.30	0.820
Chiropractor	21,000	570,000	102,600	467,400	1.000	280.00	27.14	0.63	0.11	0.52	0.820
Miscellaneous	65,000	3,600,000	648,000	2,952,000	1.000	866.67	55.38	4.00	0.72	3.28	0.820
Subtotal Physician/Other	18,838	53,465,000	9,623,700	43,841,300				59.41	10.69	48.71	0.820
Subtotal - Medical		130,415,000	13,263,700	117,151,300				144.91	14.74	130.17	0.898
Prescription Drugs	800,000	55,000,000	16,000,000	39,000,000	1.000	10,666.67	68.75	61.11	17.78	43.33	0.709
Grand Total		185,415,000	29,263,700	156,151,300				206.02	32.52	173.50	0.842

Exhibit A.2
ABC Health Plan
Summary of Claims Experience

Experience Period: Calendar Year 2004
Member Months 900,000

Service Category	Days	Allowed	Member Cost Share	Plan Paid	Incurred Adjustment Factor	Completed Util/1000	Allowed per Util	Allowed PMPM	Cost Share PMPM	Plan Paid PMPM	Implied Benefit Ratio
	2004 Claims Paid Through April, 2005										
Hospital Inpatient											
Medical/Surgical	18,270	32,700,000	930,000	31,770,000	1.005	244.82	1,789.82	36.52	1.04	35.48	0.972
Maternity	3,045	5,450,000	160,000	5,290,000	1.005	40.80	1,789.82	6.09	0.18	5.91	0.971
Complex Newborn	1,218	545,000	-	545,000	1.005	16.32	447.45	0.61	-	0.61	1.000
Subtotal	22,533	38,695,000	1,090,000	37,605,000		301.94	$ 1,717.26	43.21	1.22	41.99	0.972
SNF	812	327,000	-	327,000	1.005	10.88	402.71	0.37	-	0.37	1.000
Subtotal Hospital Inpatient	23,345	39,022,000	1,090,000	37,932,000		312.82		43.57	1.22	42.36	0.972
Hospital Outpatient											
Emergency Room	8,160	8,800,000	609,000	8,191,000	1.010	109.89	1,078.43	9.88	0.68	9.19	0.931
Laboratory/Pathology	14,280	3,300,000	190,000	3,110,000	1.010	192.30	231.09	3.70	0.21	3.49	0.942
Radiology	21,420	11,000,000	620,000	10,380,000	1.010	288.46	513.54	12.34	0.70	11.65	0.944
Surgery	8,160	22,000,000	1,280,000	20,720,000	1.010	109.89	2,696.08	24.69	1.44	23.25	0.942
All Other	11,220	165,000	10,500	154,500	1.010	151.10	14.71	0.19	0.01	0.17	0.936
Subtotal Hospital Outpatient	63,240	45,265,000	2,709,500	42,555,500				50.80	3.04	47.76	0.940
Physician/Other Services											
Surgery - Non-Maternity	43,050	10,400,000	1,920,000	8,480,000	1.015	582.61	241.58	11.73	2.17	9.56	0.815
Surgery - Maternity - Non-Delivery	10,250	130,000	23,000	107,000	1.015	138.72	12.68	0.15	0.03	0.12	0.823
Surgery - Maternity - Delivery	1,536	988,000	175,000	813,000	1.015	20.81	642.39	1.11	0.20	0.92	0.823
Anesthesia	8,713	3,640,000	640,000	3,000,000	1.015	117.92	417.77	4.11	0.72	3.38	0.824
Radiology	87,125	5,200,000	925,000	4,275,000	1.015	1,179.09	59.68	5.86	1.04	4.82	0.822
Pathology/Lab	246,000	4,160,000	730,000	3,430,000	1.015	3,329.20	16.91	4.69	0.82	3.87	0.825
E&M - Office Visits	230,625	13,520,000	2,395,000	11,125,000	1.015	3,121.13	58.62	15.25	2.70	12.55	0.823
E&M - Preventive Medicine	17,425	1,456,000	258,000	1,198,000	1.015	235.82	83.56	1.64	0.29	1.35	0.823
E&M - Inpatient Visits	20,500	1,508,000	270,000	1,238,000	1.015	277.43	73.56	1.70	0.30	1.40	0.821
Consultations	15,375	1,924,000	329,000	1,595,000	1.015	208.08	125.14	2.17	0.37	1.80	0.829
Emergency Room/Critical Care	12,300	936,000	163,000	773,000	1.015	166.46	76.10	1.06	0.18	0.87	0.826
Ophthalmology - Exams	7,175	624,000	109,500	514,500	1.015	97.10	86.97	0.70	0.12	0.58	0.825
Ophthalmology - Services	3,588	218,400	38,000	180,400	1.015	48.56	60.87	0.25	0.04	0.20	0.826
Cardiovascular	18,450	1,196,000	210,000	986,000	1.015	249.69	64.82	1.35	0.24	1.11	0.824
Allergy	17,938	260,000	45,800	214,200	1.015	242.76	14.49	0.29	0.05	0.24	0.824
Imm/Inj	46,125	988,000	173,000	815,000	1.015	624.23	21.42	1.11	0.20	0.92	0.825
Physical Medicine	20,500	494,000	87,000	407,000	1.015	277.43	24.10	0.56	0.10	0.46	0.824
Accidental Dental	513	130,000	22,500	107,500	1.015	6.94	253.41	0.15	0.03	0.12	0.827
Ambulance	1,538	400,400	71,000	329,400	1.015	20.81	260.34	0.45	0.08	0.37	0.823
DME	11,788	1,612,000	288,000	1,324,000	1.015	159.53	136.75	1.82	0.32	1.49	0.821
Home Health	16,400	1,482,000	263,000	1,219,000	1.015	221.95	90.37	1.67	0.30	1.37	0.823
Chiropractor	21,525	592,800	105,000	487,800	1.015	291.31	27.54	0.67	0.12	0.55	0.823
Miscellaneous	66,625	3,744,000	658,000	3,086,000	1.015	901.66	56.20	4.22	0.74	3.48	0.824
Subtotal Physician/Other		55,603,600	9,898,800	45,704,800				62.71	11.16	51.54	0.822
Subtotal - Medical		139,890,600	13,698,300	126,192,300				157.08	15.42	141.66	0.902
Prescription Drugs	832,000	61,050,000	16,640,000	44,410,000	1.000	11,093.33	73.38	67.83	18.49	49.34	0.727
Grand Total		200,940,600	30,338,300	170,602,300				224.91	33.91	191.00	0.849
Trend Experienced in CY 2004 From CY 2003								9.2%		10.1%	

Exhibit B
ABC Health Plan
Projected Medical Expense Budget For CY 2006

Service Type	Util	Cost	Total
	Months Of Trend		24
	Trend Factors		
Hospital Inpatient	1.0%	8.3%	9.4%
Hospital Outpatient	2.0%	11.7%	14.0%
Physician - Surgery	2.0%	3.6%	5.6%
Physician - Maternity	2.0%	2.2%	4.2%
Physician - Radiology	2.0%	5.1%	7.2%
Physician - Lab/Pathology	2.0%	3.9%	5.9%
Physician - Medicine Non-E&M	2.0%	4.1%	6.2%
Physician - Medicine E&M	2.0%	5.3%	7.4%
Prescription Drugs	4.0%	11.8%	16.3%

	Calendar Year 2004 Medical Expense Summary					Trend Factors[1]		Projected Medical Expenses Calendar Year 2006				
Service Category	Completed Util/1000	Allowed per Util	Allowed PMPM	Cost Share PMPM	Plan Paid PMPM	Util	Cost	Util/1000	Allowed per Util	Allowed PMPM	Benefit Ratio	Plan Paid PMPM
Hospital Inpatient												
Medical/Surgical	244.82	1,789.82	$ 38.52	1.04	35.48	1.020	1.173	249.74	2,099.49	$ 43.69	0.977	$ 42.67
Maternity	40.80	1,789.82	6.09	0.18	5.91	1.020	1.173	41.62	2,099.49	7.28	0.976	7.10
Complex Newborn	16.32	447.45	0.61	-	0.61	1.020	1.173	16.65	524.87	0.73	1.005	0.73
Subtotal	301.94	1,717.26	$ 43.21	$ 1.22	$ 41.99			308.01	2,014.38	$ 51.70		$ 50.51
SNF	10.88	402.71	0.37	-	0.37	1.020	1.173	11.10	472.39	0.44	1.005	0.44
Subtotal Hospital Inpatient	312.82	1,671.54	$ 43.57	$ 1.22	$ 42.36			319.11	1,960.74	$ 52.14		$ 50.95
Hospital Outpatient												
Emergency Room	109.89	1,078.43	$ 9.88	$ 0.68	$ 9.19	1.040	1.249	114.33	1,346.54	$ 12.83	0.939	$ 12.04
Laboratory/Pathology	192.30	231.09	3.70	0.21	3.49	1.040	1.249	200.07	288.54	4.81	0.950	4.57
Radiology	288.46	513.54	12.34	0.70	11.65	1.040	1.249	300.11	641.21	16.04	0.952	15.26
Surgery	109.89	2,696.08	24.69	1.44	23.25	1.040	1.249	114.33	3,366.36	32.07	0.950	30.46
All Other	151.10	14.71	0.19	0.01	0.17	1.040	1.249	157.20	18.36	0.24	0.944	0.23
Subtotal Hospital Outpatient			$ 50.80	$ 3.04	$ 47.76					$ 65.99		$ 62.57
Physician/Other Services												
Surgery - Non-Maternity	582.61	241.58	$ 11.73	$ 2.17	$ 9.56	1.040	1.073	606.15	259.12	$ 13.09	0.824	$ 10.78
Surgery - Maternity - Non-Delivery	138.72	12.68	0.15	0.03	0.12	1.040	1.073	144.32	13.60	0.16	0.832	0.14
Surgery - Maternity - Delivery	20.81	642.39	1.11	0.20	0.92	1.040	1.044	21.66	670.57	1.21	0.831	1.01
Anesthesia	117.92	417.77	4.11	0.72	3.38	1.040	1.073	122.68	448.09	4.58	0.833	3.81
Radiology	1,179.09	59.68	5.86	1.04	4.82	1.040	1.105	1,226.73	65.96	6.74	0.831	5.60
Pathology/Lab	3,329.20	16.91	4.69	0.82	3.87	1.040	1.079	3,463.70	18.24	5.26	0.833	4.39
E&M - Office Visits	3,121.13	58.62	15.25	2.70	12.55	1.040	1.108	3,247.22	64.97	17.58	0.831	14.62
E&M - Preventive Medicine	235.82	83.58	1.64	0.29	1.35	1.040	1.108	245.35	92.61	1.89	0.831	1.57
E&M - Inpatient Visits	277.43	73.58	1.70	0.30	1.40	1.040	1.108	288.64	81.53	1.96	0.829	1.63
Consultations	208.08	125.14	2.17	0.37	1.80	1.040	1.083	216.48	135.56	2.45	0.838	2.05
Emergency Room/Critical Care	166.46	76.10	1.06	0.18	0.87	1.040	1.083	173.18	82.43	1.19	0.834	0.99
Ophthalmology - Exams	97.10	86.97	0.70	0.12	0.58	1.040	1.083	101.02	94.21	0.79	0.833	0.66
Ophthalmology - Services	48.56	60.87	0.25	0.04	0.20	1.040	1.083	50.52	65.94	0.28	0.835	0.23
Cardiovascular	249.69	64.82	1.35	0.24	1.11	1.040	1.083	259.78	70.22	1.52	0.833	1.27
Allergy	242.76	14.49	0.29	0.05	0.24	1.040	1.083	252.57	15.70	0.33	0.832	0.28
Imm/Inj	624.23	21.42	1.11	0.20	0.92	1.040	1.083	649.44	23.20	1.26	0.833	1.05
Physical Medicine	277.43	24.10	0.56	0.10	0.46	1.040	1.083	288.64	26.10	0.63	0.832	0.52
Accidental Dental	6.94	253.41	0.15	0.03	0.12	1.040	1.083	7.22	274.51	0.17	0.835	0.14
Ambulance	20.81	260.34	0.45	0.08	0.37	1.040	1.083	21.66	282.01	0.51	0.831	0.42
DME	159.53	136.75	1.82	0.32	1.49	1.040	1.083	165.98	148.13	2.05	0.830	1.70
Home Health	221.95	90.37	1.67	0.30	1.37	1.040	1.083	230.91	97.89	1.88	0.831	1.57
Chiropractor	291.31	27.54	0.67	0.12	0.55	1.040	1.083	303.07	29.83	0.75	0.831	0.63
Miscellaneous	901.66	56.20	4.22	0.74	3.48	1.040	1.083	938.09	60.87	4.76	0.833	3.96
Subtotal Physician/Other			$ 62.71	$ 11.16	$ 51.54					$ 71.05	0.830	$ 59.00
Subtotal - Medical			$ 157.08	$ 15.42	$ 141.66					$ 189.18		$ 172.52
Prescription Drugs	11,093.33	73.38	$ 67.83	$ 18.49	$ 49.34	1.082	1.250	11,996.65	91.69	$ 91.68	0.727	$ 66.69
Grand Total			$ 224.91	$ 33.91	$ 191.00					$ 280.86	0.727	$ 239.21
Average Annualized Trend From CY 2004 To CY 2006										11.7%		11.9%

[1] Note that the trend factors reflect the trend rates shown in the upper left corner table, but projected for 24 months.

Exhibit C
ABC Health Plan
Development Of Inpatient Hospital Unit Cost Trend

Hospital	Calendar Year 2003 Days	Calendar Year 2003 Charge Per Day	Calendar Year 2003 Allowed Per Day	Implied Discount	Calendar Year 2004 Days	Calendar Year 2004 Charge Per Day	Calendar Year 2004 Allowed Per Day	Implied Discount	CY 2003 To CY 2004 Trend	Trend For CY 2005	Trend For CY 2006	Projected Allowed CY 2006	Average Annual Trend CY 2004 To CY 2006
Hospital A	4,500	$ 2,750.00	$ 1,127.00	59%	4,600	$ 3,025.00	$ 1,260.00	58%	11.8%	5.0%	6.0%	$ 1,402.00	5.5%
Hospital B	3,500	2,250.00	1,200.00	47%	3,550	2,475.00	1,300.00	47%	8.3%	6.0%	6.0%	1,461.00	6.0%
Hospital C	2,400	3,000.00	1,800.00	40%	2,440	3,300.00	1,870.00	43%	3.9%	12.0%	4.0%	2,178.00	7.9%
Hospital D	1,800	2,500.00	1,400.00	44%	1,850	2,750.00	1,475.00	46%	5.4%	12.0%	7.0%	1,768.00	9.5%
Hospital E	1,600	3,000.00	2,000.00	33%	1,640	3,300.00	2,100.00	36%	5.0%	8.0%	8.0%	2,449.00	8.0%
Hospital F	1,300	3,500.00	2,100.00	40%	1,340	3,850.00	2,250.00	42%	7.1%	5.0%	12.0%	2,646.00	8.4%
Hospital G	800	2,000.00	1,105.00	45%	830	2,200.00	1,195.00	46%	8.1%	3.0%	25.0%	1,539.00	13.5%
Hospital H	700	2,250.00	1,260.00	44%	710	2,475.00	1,300.00	47%	3.2%	9.0%	25.0%	1,771.00	16.7%
Hospital I	600	2,250.00	1,400.00	38%	620	2,475.00	1,500.00	39%	7.1%	10.0%	10.0%	1,815.00	10.0%
Hospital J	600	2,500.00	1,510.00	40%	600	2,750.00	1,600.00	42%	6.0%	6.0%	12.0%	1,900.00	9.0%
Hospital K	600	3,000.00	2,250.00	25%	550	3,300.00	2,350.00	29%	4.4%	5.0%	5.0%	2,591.00	5.0%
Hospital L	500	3,250.00	2,400.00	26%	540	3,575.00	2,550.00	29%	6.3%	5.0%	12.0%	2,999.00	8.4%
Hospital M	400	2,000.00	1,750.00	13%	430	2,200.00	1,900.00	14%	8.6%	20.0%	20.0%	2,736.00	20.0%
Hospital N	400	2,250.00	2,000.00	11%	450	2,475.00	2,150.00	13%	7.5%	7.0%	7.0%	2,462.00	7.0%
Hospital O	400	2,500.00	2,250.00	10%	410	2,750.00	2,400.00	13%	6.7%	10.0%	10.0%	2,904.00	10.0%
Hospital P	400	2,500.00	2,300.00	8%	390	2,750.00	2,500.00	9%	8.7%	10.0%	10.0%	3,025.00	10.0%
Hospital Q	350	2,500.00	2,325.00	7%	330	2,750.00	2,550.00	7%	9.7%	16.0%	16.0%	3,431.00	16.0%
Hospital R	300	2,500.00	2,360.00	6%	285	2,750.00	2,600.00	5%	10.2%	5.0%	5.0%	2,867.00	5.0%
Hospital S	250	2,500.00	2,360.00	6%	235	2,750.00	2,599.00	5%	10.1%	5.0%	5.0%	2,865.00	5.0%
Hospital T	200	2,500.00	2,413.00	3%	210	2,750.00	2,660.00	3%	10.2%	7.0%	7.0%	3,045.00	7.0%
Hospital U	200	2,500.00	2,410.00	4%	150	2,750.00	2,650.00	4%	10.0%	7.0%	7.0%	3,034.00	7.0%
Hospital V	130	2,500.00	2,500.00	0%	115	2,750.00	2,750.00	0%	10.0%	10.0%	10.0%	3,328.00	10.0%
Hospital W	90	2,500.00	2,500.00	0%	80	2,750.00	2,750.00	0%	10.0%	10.0%	10.0%	3,328.00	10.0%
Hospital X	70	2,500.00	2,500.00	0%	83	2,750.00	2,750.00	0%	10.0%	10.0%	10.0%	3,328.00	10.0%
Hospital Y	60	2,500.00	2,500.00	0%	53	2,750.00	2,750.00	0%	10.0%	10.0%	10.0%	3,328.00	10.0%
Hospital Z	50	2,500.00	2,500.00	0%	42	2,750.00	2,750.00	0%	10.0%	10.0%	10.0%	3,328.00	10.0%
Totals	22,200	$ 2,644.14	$ 1,599.09	40%	22,533	$ 2,908.56	$ 1,717.26	41%	7.4%	7.7%	8.7%	$ 2,014.38	8.3%
Utilization Trend Factor					1.015								

Exhibit D
ABC Health Plan
Development Of Outpatient Hospital Unit Cost Trend

Hospital	Calendar Year 2003 Visits	Calendar Year 2003 Charge Per Visit	Calendar Year 2003 Allowed Per Visit	Calendar Year 2003 Implied Discount	Calendar Year 2004 Visits	Calendar Year 2004 Charge Per Visit	Calendar Year 2004 Allowed Per Day	Calendar Year 2004 Implied Discount	CY 2003 To CY 2004 Trend	Trend For CY 2005	Trend For CY 2006	Projected Allowed CY 2006	Average Annual Trend CY 2004 To CY 2006
Hospital A	17,000	$ 897.25	$ 625.00	30%	17,100	$ 969.03	$ 675.00	30%	8.0%	20.0%	15.0%	$ 932.00	17.5%
Hospital B	11,500	776.00	570.00	27%	11,700	838.08	610.00	27%	7.0%	12.0%	10.0%	752.00	11.0%
Hospital C	7,200	921.50	690.00	25%	7,450	995.22	735.00	26%	6.5%	12.0%	10.0%	906.00	11.0%
Hospital D	6,300	800.25	615.00	23%	6,450	864.27	660.00	24%	7.3%	12.0%	10.0%	813.00	11.0%
Hospital E	4,700	911.80	765.00	16%	4,800	984.74	820.00	17%	7.2%	8.0%	12.0%	992.00	10.0%
Hospital F	2,800	1,164.00	980.00	16%	2,850	1,257.12	1,050.00	16%	7.1%	4.0%	8.0%	1,179.00	6.0%
Hospital G	2,000	640.20	545.00	15%	2,100	691.42	585.00	15%	7.3%	7.0%	8.0%	676.00	7.5%
Hospital H	1,650	722.65	620.00	14%	1,700	780.46	670.00	14%	8.1%	9.0%	8.0%	789.00	8.5%
Hospital I	1,250	703.25	605.00	14%	1,300	900.00	785.00	13%	29.8%	9.0%	10.0%	941.00	9.5%
Hospital J	1,000	829.35	725.00	13%	1,030	895.70	785.00	12%	8.3%	3.0%	10.0%	889.00	6.4%
Hospital K	850	1,018.50	895.00	12%	870	1,099.98	965.00	12%	7.8%	5.0%	5.0%	1,064.00	5.0%
Hospital L	810	1,071.85	955.00	11%	820	1,157.60	1,030.00	11%	7.9%	5.0%	5.0%	1,136.00	5.0%
Hospital M	720	659.60	590.00	11%	740	712.37	635.00	11%	7.6%	7.0%	7.0%	727.00	7.0%
Hospital N	610	712.95	650.00	9%	620	769.99	700.00	9%	7.7%	13.0%	13.0%	894.00	13.0%
Hospital O	560	800.25	725.00	9%	570	864.27	785.00	9%	8.3%	13.0%	13.0%	1,002.00	13.0%
Hospital P	500	819.65	745.00	9%	510	885.22	800.00	10%	7.4%	10.0%	10.0%	968.00	10.0%
Hospital Q	410	868.15	820.00	6%	420	937.60	885.00	6%	7.9%	12.0%	12.0%	1,110.00	12.0%
Hospital R	360	873.00	835.00	4%	370	942.84	902.00	4%	8.0%	10.0%	10.0%	1,091.00	10.0%
Hospital S	400	824.50	785.00	5%	420	890.46	850.00	5%	8.3%	10.0%	10.0%	1,029.00	10.0%
Hospital T	380	848.75	815.00	4%	390	916.65	880.00	4%	8.0%	10.0%	10.0%	1,065.00	10.0%
Hospital U	350	873.00	845.00	3%	360	942.84	910.00	3%	7.7%	7.0%	7.0%	1,042.00	7.0%
Hospital V	300	725.00	725.00	0%	310	785.00	785.00	0%	8.3%	7.0%	7.0%	899.00	7.0%
Hospital W	120	810.00	810.00	0%	130	870.00	870.00	0%	7.4%	7.0%	7.0%	996.00	7.0%
Hospital X	110	820.00	820.00	0%	110	885.00	885.00	0%	7.9%	7.0%	7.0%	1,013.00	7.0%
Hospital Y	90	835.00	835.00	0%	90	900.00	900.00	0%	7.8%	7.0%	7.0%	1,030.00	7.0%
Hospital Z	30	780.00	780.00	0%	30	830.00	830.00	0%	6.4%	10.0%	10.0%	1,004.00	10.0%
Totals	62,000	$ 858.27	$ 663.71	23%	63,240	$ 929.75	$ 715.77	23%	7.8%	12.7%	11.2%	$ 893.72	11.7%
Utilization Trend Factor					1.020								

Exhibit E
ABC Health Plan
Development Of Physician/Othert Unit Cost Trend

		CY 2004		CY 2005		
Medical Expense Category	Volume	Units	Cost Per Service	Units	Cost Per Service	Trend[1]
Surgery	55,000	6.00	221.40	6.05	229.30	3.6%
Surgery - Maternity	1,500	38.00	1,402.20	37.80	1,432.62	2.2%
Radiology	87,000	1.70	62.73	1.74	65.95	5.1%
Laboratory/Pathology	245,000	1.80	66.42	1.82	68.98	3.9%
Medicine Non-E&M	275,000	1.50	55.35	1.52	57.61	4.1%
Medicine E&M	270,000	2.00	73.80	2.05	77.70	5.3%
Total	933,500	2.07	76.23	2.10	79.50	4.3%

[1] Estimated Trend for 2005 over 2004 that represents best estimate of trend for 2006.

Exhibit F
ABC Health Plan
Development Of Prescription Drug Unit Cost Trend

Scrip Catgegory	Prescriptions	CY 2003 Cost Per Service	CY 2004 Cost Per Service	CY 2004 Over CY 2003 Trend
Brand Name Scrips	520,000	80.00	90.00	12.5%
Generic Scrips	280,000	26.00	28.00	7.7%
Total	800,000	61.10	68.30	11.8%

DEPARTMENT OF VETERANS AFFAIRS
Medical Center
Alexandria, Louisiana 71306-9004

May 3, 2005 In Reply Refer To: 502/00PA

Dear Friend:

As of April 29, 2005, the Alexandria VA Medical Center is no longer scheduling appointments for new Non Service Connected (NSC) veterans. New NSC applicants will be enrolled and placed on a waiting list for a future appointment. This measure is necessary in order to maximize existing resources and to ensure that the veterans currently receiving health care at the Medical Center continue to receive high quality care. NSC veterans in special categories, i.e., homeless, chronically mentally ill, spinal cord injury, veterans in State Homes, and those recently returning Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) veterans are not affected by this change.

This new process does not affect Service Connected (SC) veterans or any NSC veteran currently enrolled. Patients who fail to keep scheduled appointments will be contacted and may be given the opportunity to call for a future appointment at their convenience rather than having VA schedule an advanced appointment for them.

This suspension may be temporary, depending upon the available resources and is in effect at all VA Medical Centers within the South Central VA Healthcare Network (VISN 16). When we are able to begin seeing new Non Service Connected veterans outside the special categories, those on the waiting list will be notified and appointments scheduled.

Should you have additional questions regarding this matter, please do not hesitate to contact Mr. Jay DeWorth, Administrative Assistant to the Director, at 318-473-0010, extension 2010, or Ms. Lakeeshun Obey, Enrollment Coordinator, at extension 2763.

Sincerely,

Barbara C. Watkins
Medical Center Director